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THE UNIVERSITY OF ALBERTA

FACING CHANGE: RELATIONSHIPS BETWEEN STYLES OF LIVING AND STYLES OF DYING

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF DOCTOR OF PHILOSOPHY

IN

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DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

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To Greg and Randy

ABSTRACT

The concept of life style as a pattern of behavior that emerges most clearly in times of change has been widely discussed in the literature. In this study dying was defined as part of the living process in which one is faced with an experience of change. The study was conducted to assess the relationship between responses to the change experience of dying and the manner in which other experiences of change in the living process were handled.

Twenty-one subjects who were currently (or had been) faced with a life-threatening illness were interviewed and 17 of these subjects were administered the Living-Style/Dying-Style Questionnaire (LS/DSQ), an instrument based on Keleman's (1974) concept of eruptive and congealing response patterns. Interviews were conducted in accordance with a semi-structured interview schedule developed by the researcher to determine patterns of response to life-change experiences and the threat of dying. All interviews were tape recorded. The LS/DSQ was designed by the researcher to (a) obtain information beyond that which was presented in the interview about subjects' perceptions of how they responded to change, (b) determine whether this information and the interview material were consistent, and (c) assess whether the categorization of eruptive and congealing response patterns was a useful one in assessing reactions to change.

Subjects defined change experiences in a consistent manner. Types of change experiences fell into four major categories. They were

primarily situational (as opposed to developmental) and were not found to have specific time limitations. Two primary coping patterns emerged on the LS/DSQ in response to change and were labelled eruptive and congealing. The behavioral and affective traits, the response to and the perception of change experiences were different for these two groups. The overall trend of the results suggested, however, that there was a consistent response to change, life-threatening illnesses included. Despite the fact that different modes were frequently chosen for handling the prospect of dying, they did not vary to any significant degree from overall patterns of coping with change. The possible bases for these results and their implications for counselling were discussed.

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TABLE OF CONTENTS

CHAPTER		PAGE
I.	INTRODUCTION	1
	General Statement of the Problem	1
	Overview of the Problem	2
	Research Questions	6
II.	REVIEW OF RELATED LITERATURE	7
	The Concepts of Unity and Consistency in Personality Theory	7
	Theory and Research and Coping with Change	11
	Definitions of Change	12
	Theories of Change	15
	Death, Dying and Change	19
	Styles of Coping with Change	19
	Death and Dying	23
	Death Fear and Death Anxiety	24
	Theoretical Considerations of Death and Dying	25
	Death and Dying from a Research Perspective	28
	Sex	29
	Age	31
	Religion	34
	Dying	37
	An Integration of the Literature	43
III.	METHODOLOGY	46
	Procedure and Design	46

CHAPTER PAGE

Sample 46

Pilot study 46

Subjects 46

Procedure 47

Instruments 48

Interview Schedule 48

Living-Style/Dying-Style Questionnaire 52

Definitions Used to Guide the Research 53

Analysis of Data 55

IV. RESULTS 56

Case Descriptions 56

Demographic Information 90

Change Experiences: Description, Characteristics and Outcome 93

Description 93

Characteristics 94

Outcome 96

Styles of Coping with Change 97

The Practical Approach to Change 97

Outer-Directed vs. Inner-Directed Persons: Coping with Change 98

The eruptors 102

The congealers 104

The mixed group 108

Styles of Coping with Life-Threatening Illness 109

Response to Life-Threatening Illness and the Threat of Dying 110

CHAPTER PAGE

Life-Threatening Illness as a Catalyst for a Life Style Change 112

Relationship Between Patterns of Coping with Life Change Experiences and Life-Threatening Illnesses: An Overview 113

V. DISCUSSION AND IMPLICATIONS 117

Limitations of the Investigation 117

Discussion of the Research Questions 119

How Do Subjects Define Change Experiences? 119

Do Identifiable Coping Patterns Emerge in Response to Change? 123

Does Consistency Exist in the Manner that Subjects Respond to General Life Change Experiences and those that are related to Life-Threatening Illnesses? 125

What Subject Attitudes and Behaviors Emerge in Relation to the Prospect of One's Personal Dying Process? 128

Is Keleman's (1974) Description of Eruptive and Congealing Response Patterns a Useful one in Assessing Reactions to Change? 130

Implications 131

Implications for Research 131

Implications for Counselling 132

* * *

REFERENCES 136

APPENDIX A. CONSENT FORM FOR SUBJECTS REFERRED BY THE CITY OF EDMONTON HOME CARE SERVICE PROGRAM 146

APPENDIX B. LETTER TO THE DIRECTOR, CITY OF EDMONTON HOME CARE SERVICES PROGRAM CONFIRMING REFERRAL ARRANGEMENTS . . 148

APPENDIX C. CONSENT FORM FOR SUBJECTS NOT REFERRED BY THE CITY OF EDMONTON HOME CARE SERVICE PROGRAM 150

PAGE

APPENDIX D. INTERVIEW SCHEDULE 152

APPENDIX E. RESUME OF THE RESEARCHER'S WORK EXPERIENCE AND ACADEMIC QUALIFICATIONS 155

APPENDIX F. REQUEST FORM FOR DESCRIPTIONS OF ERUPTIVE AND CONGEALING RESPONSE PATTERNS 158

APPENDIX G. THE LIVING-STYLE/DYING-STYLE QUESTIONNAIRE 160

APPENDIX H. KEY FOR THE LIVING-STYLE/DYING-STYLE QUESTIONNAIRE . . .165

LIST OF TABLES

Table	Description	Page
1.	Age Of Respondents	90
2.	Marital Status of Respondents	90
3.	Educational Level of Respondents	91
4.	Religious Affiliation as Described by Respondents	92
5.	How Respondents Defined Change Experiences	94
6.	Eruptive and Congealing Responses on the LS/DSQ	100
7.	Percentage and Percentage Difference of Total Eruptive and Congealing Responses on the LS/DSQ	101
8.	Public/Private Responses on the LS/DSQ	105
9.	Victim/Participant Responses on the LS/DSQ	105
10.	Closed/Open Responses on the LS/DSQ	105
11.	Passive/Active Responses on the LS/DSQ	106
12.	Withdrawing into Self/Moving Toward Others Responses on the LS/DSQ	106
13.	Dependent/Independent Responses on the LS/DSQ	106
14.	Respondents' Perception of Life-Threatening Illness as a Change Experience	110
15.	Respondents' Expressed Fear of Dying	110
16.	Agreement Responses on the LS/DSQ	116

CHAPTER I

INTRODUCTION

General Statement of the Problem

The relationship between attitudes toward life and living and attitudes toward death and dying are treated in the psychological literature by authors of a variety of theoretical orientations (Klug, 1976; Wahl, 1959, Zilboorg, 1943). While the terms life and living and the terms death and dying are frequently discussed as if they were synonymous, for the purpose of this study they were regarded as distinct and separate. The focus of this research is on specific aspects of the relationship between living and dying, and included material on life and death only in the context of its general theoretical significance to living and dying.

In this thesis dying is defined as part of the living process in which one is faced with a significant experience of change in that process. Keleman (1974) referred to this as a turning point. This research examined the relationship between subjects' approaches to the specific change experience of dying and the manner in which other change experiences within the living process were handled. The major question in this study is whether there is a pattern in which individuals react to change in their lives that is consistent throughout the living process and is reflected in reaction to the dying process. Subjects' responses to change experiences were assessed by data collected in interviews and by an instrument designed to measure Keleman's

(1974) concepts of self-extending (eruptive) and self-collecting (congealing) styles of life expression.

Overview of the Problem

Some investigators regard death and dying as entities separate from those of life and living. Considerable effort has been directed toward isolating and analyzing the dying process and providing directives to assist dying patients cope with it emotionally and practically. An example of this trend can be found in the work of Kübler-Ross (1969). Another body of literature clearly connects dying processes to those of living. Schneidmann (1963) postulated that a view of living and dying as "distinct, separate, almost dichotomous activities" (p. 205) is erroneous. This orientation is strongly supported by Feifel (1959) who maintained that the manner in which an individual lives is directly related to his philosophical orientation toward life and death.

Authors who address the aformentioned issue, linking living to dying, are in basic agreement with Guthrie's (1969/1971) statement that "in relating to one who is facing the imminence of death . . . we are dealing with a set of behavior patterns that usually has a long history for the individual concerned. A person's whole style of life is involved in a person's way of dealing or not dealing with death" (p. 302). Keleman (1974) elaborated on this statement in his exploration of the relationship between living and dying styles. He is of the opinion that any distinct style for dying is really a program for dying. However, regardless of the style in which individuals ultimately die, he stressed they have some control

over their dying and "the decision to integrate our dying style, to not fear dying as a viable alternative, strengthens our life" (p. 156). In this context, the relationship between dying and living styles is clear. Keleman maintained that most people live their dying as they have lived their lives.

Life style, as a psychological term, received its strongest impetus from Adlerian theory. "For Adler life style represented the organismic ideas of the individual as an actor rather than a re-actor; of the purposiveness, goal-directedness, unity, self-consistency and uniqueness of the individual; and of the ultimately subjective determination of his actions" (Ansbacher, 1967, p. 191). Life style, in this framework, can be defined as an individual pattern of movement (Croake, 1975). Adler (1930/1952) further stated that life style cannot be seen clearly when one is in a favorable situation, but tends to be more distinct when one is confronted with difficulties. In general usage and in Adlerian psychology, life style appears to be a multidimensional concept that is most useful in determining patterns of behavior.

Another definition of living style, which is explicitly examined in its relationship to dying style, is offered by Keleman (1974). He identified two fundamental characteristics of human life and labelled them self-extending (expansive) and self-collecting (solidifying). A person in the former mode disperses his experience into the world, moves out into the social world. A person in the latter mode gathers his experience to himself, has more contact with himself than the external world. From these characteristics evolve two styles of dying--eruptive

and congealing. The eruptive style is consistent with the self-extending phase in which the organism explodes, breaking out of its boundaries into the world. Strokes and heart attacks are examples of eruptive dying. The congealing style is associated with the self-collecting phase. It is the opposite of the eruptive. It is self-inhibited, withdrawing. Such a style of dying is often characterized by a series of illnesses, frequently lengthy. The congealing and eruptive cycles are not restricted to dying. They clearly are aspects of life patterns, "a natural continuity of a general style of life expression . . . fundamental to the organism, fundamental to all life processes" (Keleman, 1974, p. 15) and, as such, are apparent in both living and dying.

If individuals possess a style of life, is this style reflected in the manner in which they cope with change in their lives? Descriptions of change events as well as the manner in which individuals respond to them are extensively dealt with in the literature. Experiences of change are described in different ways (i.e. transition points, life crises, marker events). For the purpose of this study, these terms were regarded as descriptive of the same concept.

Despite the use of different terminology, considerable agreement exists regarding definitions and characteristics of change experiences, namely (a) their quality of discontinuity and disruption, and (b) the fact that behavioral and/or interpersonal shifts are associated with such experiences. Hopson and Adams (1976) clearly define transition as a discontinuity in the life space of an individual. The quality of discontinuity is also identified by Marris (1974) in his discussion of

change, and crisis is referred to as a period of disequilibrium by Parad and Caplan (1960/1965). Keleman's (1974) reference to turning points as "life's upswellings" (p. 21) is also consistent with the above view.

Developmental theorists have also devoted considerable attention to the specific effects of change experiences. Erikson (1968), in his theory of developmental psychology, described crises as having the potential for psychological growth or maladjustment. The fact that shifts evolving from change experiences can take either a positive or negative direction is a familiar thread in discussions of change. Rapaport (1962/1965), in this vein, referred to crises as having potential for either maturation and development or poorer mental health. Keleman (1974) supported this view in his reference to turning points as providing a focus of new directions. Unlike most authors, however, he directly connected turning points to dying, maintaining that there "are no turning points that are not accompanied by feelings of dying, no self-formings occur without ending and loss" (p. 26).

In summary, the concept of life style as a pattern of behavior (that is most readily detected in times of change) has received considerable attention. In this investigation, dying was defined as an experience of change and the research was designed to explore whether response to dying has a style that is related to life style. The examination of life style was restricted to the manner in which subjects responded to change. In consideration of the above, the present study was concerned with several questions.

Research Questions

1. How do subjects define change experiences?

2. Do identifiable coping patterns emerge in response to change?

3. Does consistency exist in the manner that subjects respond to general life change experiences and those that are related to life-threatening illnesses?

4. What subject attitudes and behaviors emerge in relation to the prospect of one's personal dying process?

5. Is Keleman's (1974) description of eruptive and congealing response patterns a useful one in assessing reactions to change?

CHAPTER II

REVIEW OF RELATED LITERATURE

This review is divided into four parts. The first three examine material on areas pertinent to this study, (a) the concepts of unity and consistency in personality theory, (b) theory and research on coping with change, and (c) death and dying. An integration of the literature is then presented.

The Concepts of Unity and Consistency in Personality Theory

Stated simply, personality refers to "characteristic ways in which a person reacts to life situations" (Jourard, 1963, p. 3). Implicit in Jourard's definition is a view of personality as a pattern of behavior, a common denominator of many theories of personality. A brief overview of the theories of Alfred Adler, Gordon Allport and Kurt Goldstein, all of which stress the consistency and unity of personality structure and individual behavior, will be utilized to examine this definition more closely.

Adler believed that style of life is the key to behavior and can be equated with one's basic character (Munroe, 1955). His theory is conceptualized within the framework of the character, development and function of life style.

To Adler, feelings of inferiority are universal and, to compensate for them, each person develops a unique goal early in life, referred to as the goal of superiority. In attempts to attain this goal, life is conducted in a prescribed manner that Adler defined as

the style of life, an individual pattern of movement. It is a unique method of perceiving, behaving and striving toward a subjectively defined goal (Ansbacher & Ansbacher, 1956) and, thus, possesses both behavioral and subjective components. Adler postulated that life style (a) is formulated in early childhood, (b) is influenced by physical and social, as well as psychological conditions, and (c) tends to be most distinct in new situations when one is faced with difficulties; it is less clear in favorable situations.

An understanding of Adlerian life style theory is amplified by attention to its consistency, uniqueness and holistic character. The style of life is both unified and unique. Its self-consistency is reflected in all aspects of individual functioning--feeling, thinking, acting, conscious and unconscious behavior. Adler maintained that, once established, it remains stable throughout life unless deliberate attempts are made to change it; "the individual still shows the same line of movement . . . in childhood as in adulthood" (Ansbacher & Ansbacher, 1956, p. 190). Simultaneously, each life style is unique to the person who developed it. Evolving from this view is Adler's (a) caution against the use of types, similarities and rules, and (b) emphasis on the importance of attending to individual variations and nuances, in the interpretation of human behavior. Finally, the life style concept can be regarded as holistic in that aspects of behavior can be understood only in relation to the "whole," in this instance, the pattern reflected by the style of life.

> One can never regard single manifestations of the mental life as separate entities . . . one can gain

> understanding of them only if one understands all manifestations of a mental life as parts of an indivisible whole, and then attempts to uncover the line of movement, the schema of life . . . the style life (Ansbacher & Ansbacher, 1956, p. 90).

The similarities and differences between Adler's personality theory and that of Gordon Allport have been outlined and discussed by Long (1952) who classified both as organismic, holistic theories that rejected the use of typologies and stressed the existence of creativity, intentionality and striving in human functioning.

Like Adler, Allport emphasized the concept of unity in personality and concluded that "even though a person's life exhibits contradictory trends, even though the unity is never complete and final, it is nevertheless obvious that the number of totally independent qualities is not very great" (Allport, 1937/1971, p. 138). Allport departed from Adler on his view of unity as never completed; to Adler it represented a more basic tenet. Individual uniqueness is also strongly emphasized by Allport who described individuality as the most outstanding characteristic of man. Personality is viewed, not as general in nature, but as peculiar to individuals and, consequently, the only laws of behavior that stimulated Allport's interest were those that applied to any given person (Bischof, 1964).

Allport also supported the assumption that behavior is consistent. For example, in describing the results of his study of 90 survivors of the Nazi Revolution, he devoted a section to the "enduring consistency of personality" and maintained that "the most vivid impression gained by our analysts from this case-history material is of the extraordinary continuity and sameness in the individual" (Allport, Bruner & Jandorf,

1941/1955, p. 433). However, a full understanding of Allport's views cannot be accomplished without an examination of his concepts of the "proprium" and "functional autonomy," concepts that underlie his theory of motivation. Allport coined the term proprium to define the organizing tendencies which determine attitudes and evaluations and provide the personality with consistency and congruence; the functions of the proprium influence the development of traits. Allport's theory of motivation is expanded by the principle of functional autonomy which states that "a given activity or form of behavior may become an end or a goal in itself, in spite of the fact that it was originally engaged in for some other reason" (Hall & Lindzey, 1957, p. 269).

These concepts are in disagreement with aspects of Adler's life style concept in that (a) the proprium develops over time; personality is, therefore, not determined so early in life and, thus, consistency is found most frequently in mature individuals, and (b) the concept of functional autonomy places the basis of behavior in the present, ascertaining that "the motivation behind consistent behavior may radically change from the age of five to adulthood" (Long, 1952, p. 46).

The description of normal personality functioning as integrated, unified, consistent and coherent is embodied in a third theoretical position, Kurt Goldstein's organismic approach. The term "organism," referred to throughout his discussions, is synonymous with personality. Goldstein underscored the necessity of studying the entire personality, asserting that "ever and again, the principle of the close relationship of the individual phenomenon to the 'whole' of the organism forces itself upon us" (Goldstein, 1939, p. 59). To Goldstein,

organization is the organism's natural state (while disorganization is pathological), constancy (which is reflected in the maintenance of a strong behavior pattern) characterizes its functioning and self-actualization is its only motive. The concept of equalization, in which the organism strives to maintain an "average" tension state, is the basis of the orderliness and coherence of behavior. Consistent with his view of personality, Goldstein advocated the comprehensive study of one individual as opposed to an extensive examination of an isolated psychological function obtained from many persons (Hall & Lindzey, 1957).

Adler, Allport and Goldstein disagreed on some aspects of personality theory which have not been closely analyzed in this review. However, their similarities, compared to other theories, far outweigh their differences. The main point on which they agreed is that individual patterns of behavior are consistent and enduring.

Theory and Research on Coping with Change

Kimmel (1974) defined two aspects of the personality system--content and process. Content aspects are objectifiable (personal styles, roles, self-perceptions, the self-concept) and tend to be relatively stable. That component of the system that reacts, experiences, feels is the process aspect which provides the possibility of innovative change. Personality, thus defined, makes allowance for both consistency and change. This view is supported by Mischel (1969) who stated "that in order to be more than nominally dynamic our personality theories will have to have as much room for human discrimination as for generalization, as much place for personality change as for

stability, and as much concern for man's self-regulation as for his victimization by either enduring intrapsychic forces or by momentary environmental constraints" (p. 1017).

"Change," in the above references, is a general concept. On closer examination, how can it be identified? How is it theoretically defined and what are the ways in which individuals react to and deal with it?

Definitions of Change

The experience of change is associated with a variety of terminologies (i.e. marker events, turning points, stressful life events, life crises, points of transition). Sheehy (1977) referred to life crises as "passages." These terms are often used interchangeably and are defined in both similar and dissimilar contexts.

An analysis of the nature of change is frequently made in relation to the concept of crisis. Crisis theory, as developed by Caplan (1964), utilizes the assumption that individuals normally function in consistent patterns, facing life problems with a variety of habitual problem-solving mechanisms. When these mechanisms fail, a crisis occurs, defined by Caplan as "an imbalance between the difficulty and importance of the problem and the resources immediately available to deal with it" (Caplan, 1964, p. 39). Crisis is generally seen as a time-limited period of disequilibrium out of which the potential for either psychological growth or deterioration evolves (Caplan, 1964; Moos, 1976).

The classification of crisis into special categories is frequently made and is associated with the development of crisis inter-

vention procedures. Aguilera, Messick and Farrell (1970), for example, referred to "maturational" and "situational" crises while Lieberman (1975) considered crises to be of two major types--events associated with loss and situations that disrupt customary behavior modes. Baldwin (1978) identified six classes of emotional crises--dispositional, crises of anticipated life situations, crises resulting from traumatic stress, maturational/developmental crises, crises reflecting psychopathology and psychiatric emergencies. Identification of the phases of crisis is also consistent with a focus on crisis intervention. Crisis is believed to be recognized by the following characteristics:

a) Crisis is acute rather than chronic and extends from one to six weeks.
b) It produces marked changes in behavior, which is commonly less efficient than usual.
c) There are subjective feelings of helplessness, ineffectiveness, anxiety, fear, guilt and defensiveness.
d) Although there are common crisis situations the individual's own perceptions of threat are unique, so that crisis is relativistic (Miller & Iscoe, 1963, quoted in Eastham, Coates & Allodi, 1970, p. 466).

The latter point is supported by others who also emphasize the importance of individual reactions to the situation, as opposed to defining the situation itself as the most important variable (Calhoun, Selby & King, 1972).

Differentiation between stress and crisis is made by some investigators. Rapoport (1962/1965) observed that, although these terms are often interchanged, stress has a pathogenic potential while crisis is characterized by a growth-producing potential. Lazarus (1966) elaborated on the former notion, associating stress

with negative affective phenomena (such as conflict, frustration, fear, anger); he provided a definition of stress in the framework of interaction between the individual and the external situation. There is further indication of the connection between stress and crisis in the treatment of crisis as a unique, acute phenomenon that is part of the more general glass of stress (Eastham et al., 1970).

Similarities between definitions of both stress and crisis and that of transition are also apparent. Hopson and Adams (1976) described transition as a "discontinuity in a person's life space of which he is aware and which requires new behavioral responses" (p. 24). Like crises, transitions follow a predictable course and have "opportunity value" for the person involved. All transitions have a stress component which varies in duration and intensity.

Although most authors are in agreement that experiences of change can result in either increased psychological growth or deterioration, several emphasize their growth-producing potential. The connection between crisis and growth is clearly made by Forer (1963) who defined crises as opportunities for significant growth and creativity. Summarizing the orientation of a Los Angeles Psychiatric Service, he emphasized that (a) changes related to the need for crisis resolution can be directed by internal or external events, (b) changes may be enduring, adaptive or maladaptive, and (c) the changes can have a widespread effect on total adjustment or be situation-specific.

Authors who emphasize a process orientation toward life unequivocally favor a view of change as necessary for psychological

growth. Both Moustakas (1977) and Keleman (1974) referred to experiences of change as turning points. Moustakas defined them as times of crisis, challenge and upheaval that move the individual toward a deeper sense of self. Keleman (1974), in agreement, referred to them as life's upswellings (which provide a focus of new directions). He regarded life as a series of such transitions which, when viewed in process, require time for separating, waiting and reorganizing new action (Keleman, 1974).

In summary, change experiences are defined in a variety of ways that emphasize their etiology and character. Underlying all definitions is acceptance of (a) their quality of disequilibrium and upheaval, (b) the fact that old forms of behavior are not successful in resolution of the "problem," and (c) the premise that the outcome can evolve in a psychologically positive or negative direction. Less agreement exists on the time constraints of such experiences and whether, in fact, they are required for healthy psychological development. Finally, although experiences of change are not consistently defined in a negative framework, the trend is strongly in that direction. Other orientations to change are thereby neglected, de-emphasizing the possibility that positive (as well as negative) experiences may have the potential for promoting change.

Theories of Change

Crisis theory is grounded in the concept of homeostasis, in which man's striving toward a state of equilibrium is viewed as the basic law of human motivation. Thus defined, it has a great deal in common with

the traditional psychoanalytic model of behavior and motivation (Ewing, 1978).

Despite the observation that psychoanalysts are increasingly using the concept of homeostasis (Wilder, 1966), it has been the object of widespread criticism (in general terms and in the context of its relationship to crisis theory). Taplin (1971), in his critique of crisis theory, regarded homeostatic models as failing to adequately account for development, growth and change in personality. Allport (1961), in agreement, referred to homeostasis as a "stay-put" conception which emphasizes stability rather than growth. In an earlier work, he placed homeostasis in the category of closed systems of personality which stress permanence rather than change (Allport, 1960). He countered this view with a description of personality as an open system in which "progressive levels of order through change in cognitive and motivational structure" (Allport, 1960, p. 308) could be achieved. Most critics of homeostasis are, therefore, proponents of theoretical positions that regard both maintenance and change as basic life tendencies, leaning toward Keleman's (1979) proposition that "the peculiarity of the human organism is that it thrives on stability even though there is a perpetual urge toward growth and change" (p. 67).

Another perception of change is presented by theorists who promote a stage model of human development. The most prominent author in this area is Erik Erikson who outlined eight life stages (Erikson, 1963), the first four occurring between birth and puberty and the last four characterizing the life cycle from puberty to death.

Erikson postulated that there is a "crisis" inherent in each stage that needs to be successfully resolved before the individual can adequately handle the subsequent state. However, it is crucial to note that Erikson used the term crisis "in a developmental sense, not to connote a threat of catastrophe, but a turning point, a crucial period of increased vulnerability and heightened potential, and therefore, the ontogenetic source of generational strength and maladjustment" (Erickson, 1968, p. 96). This casts change and crisis in the light of normal events in the life cycle which (similar to the opinions of Caplan and Rapport) provide the potential for development in either a positive or negative direction.

Bühler (Kimmel, 1974) analyzed 400 biographies and also formulated her theory on the basis of life stages. Her emphasis was not on the tasks of such stages, but on the parallel between biological processes of growth, stability and decline and the psychosocial process of expansion, culmination and contraction. In her view, there are two basic life tendencies--growth-expansion and contraction. The turning point between these polar trends occurs in mid-life (between 40 and 45), although Bühler recognized this shift is influenced by a combination of social, biological and psychological factors that may affect individuals in different ways.

Riegel (1975) criticized both Erikson's and Buhler's theories for not providing adequate explanations of the basis for human development. He maintained that development takes place along four planes of progression--individual-psychological, cultural-sociological, inner-biological and outer-physical. When discordance among these progressions

occurs, a crisis develops. To Riegel, crisis is not a pathological or fatalistic occurrence. To the contrary, crises present opportunities for change and are the "knots" that tie together structural changes on the cultural, physical, biological and psychological levels.

Theories of aging also contribute information on developmental changes. Atchley (1977) summarized three theories of aging.

1. Disengagement theory. A process occurs in which response to aging is characterized by gradual withdrawal from the roles in which individuals were occupied in middle age. A new equilibrium, centered on one's inner life is established.

2. Activity theory. The activity level of middle age is maintained. Successful aging, in this context, involves the maintenance of and activity in a large number of roles.

3. Continuity theory. It operates on the premise that an aging individual is inclined to maintain those preferences, associations, habits, etc. that are part of the personality pattern.

These theories present different adaptational approaches to aging and, therefore, have different implications for the field of gerontology. However, whatever theoretical position is favored, aging is not a simple process but involves accommodation to many life changes. The assumptions that (a) behavior takes place within the context of individual life style, and (b) individuality is reflected in interaction with the physical and social environments, are no less valid for the aged than for their younger counterparts (Atchley, 1977; Kimmel, 1974).

Death, Dying and Change

A small body of literature addresses the relationship between death and dying and the concept of change. Keleman (1974) associated change with dying in his discussion of "big dying" and "little dying". The former is dying as it is conventionally described, that which culminates in death. The latter relates to those changes that occur throughout life, the "breaking with the old and establishing the new" (Keleman, 1974, p. 5). From Keleman's viewpoint, these types of dying are similar (in terms of the process and feelings involved) and part of the function of "little dying" is to give the individual insight into what "big dying" might be like. Fisher (1969/1971), described the association between death and change along similar lines. Referring to death as a change point in a process of experience, he postulated that whenever parts of individuals change, those parts die in the sense that they no longer hold the positions of psychological strength that they previously did. In viewing the relationship between change and dying in yet another context, Imara (1975) contended that, when encountering important life change situations, individuals experience a process similar to that of dying persons. In this framework, dying is perceived as a developmental sequence in the life process.

Styles of Coping with Change

Coping is generally referred to as the "degree to which the individual can mobilize his action energy to realize his ends and expectations" (Williams & Wirths, 1965, p. 9). However, an examination of the literature indicates coping is defined in various ways.

Lieberman (1975), summarized the findings of other investigators and stated that two primary themes emerge in the description of coping processes, (a) mastery and competence, and (b) absence of breakdown (which is linked with the concept of homeostasis). An example of the former pattern can be found in the association of coping with control activities, whereby influence is exerted in a manner that will result in needs being adequately met (Duckworth, 1976). Coping methods are sometimes broken down into types. Lazarus (1966) identified two classes of coping that involve different processes--action tendencies (which attempt to eliminate the threat) and cognitive maneuvers (in which evaluation is changed but no direct action is taken).

Beyond the definitions of coping, the manner in which individuals cope, their "style" of coping, is examined. Procedures employed to assess coping styles are based on (a) the assumption that past behaviors are the best predictors of future behaviors across similar situations, and (b) assessment of individual traits (Lieberman, 1975). Discussion in this area often includes a classification of modes of coping as adaptive or maladaptive, particularly in that segment of the literature related to crisis intervention.

Coping styles have been found to develop early in life. Murphy (Bühler and Goldenberg, 1968) described the great individuality in coping styles of nursery school children. She identified degree of sensitivity, drive, developmental balance and autonomic reactivity to be among the significant determinants of style. Adult styles are outlined by Hopson and Adams (1976) who described three transitional

coping styles in which (a) the new situation is not accepted or is viewed as having nothing valuable to offer compared to the previous situation, (b) all aspects of the new situation are accepted; the previous situation is rejected, and (c) the individual evaluates the personal significance of the transition.

In the above descriptions, only the third style is regarded as functional. In other studies, more specific evaluations are made of coping behaviors as adaptive or maladaptive. Rapoport (1962/1965), for example, described magical thinking, excessive fantasy, regressive behavior, somatization and withdrawal from reality as maladaptive; accurate cognitive perception of the situation, successful management of affect and developing avenues to seek and use help with tasks and feelings, are associated with healthy crisis resolution.

Coping styles are further examined in relation to specific populations. Pollack (1971) used a sample of 188 college students and divided crisis and responses into three categories--crisis (frustration, conflict, external pressure), responses (substitute satisfaction, anxiety and coping). The results indicated that the nature of the crisis and type of response are related. Conflict was the most difficult crisis to solve, change of goals was the most frequent response to frustration and active coping behaviors were commonly engaged to deal with external pressure. Moriarty and Toussieng (1975) used a younger population and concluded that individuals dealing with the adolescent transition could be divided into two groups, Sensers and Censors. The styles of coping of each group were different. Censors accepted and relied on traditional views handed down to them to deal

with their world; Sensers used their "senses" to develop a more unique, personal world view. These authors also noted that "the seeds for the coping styles were sown long ago and do not come primarily from the peer group" (Moriarty & Toussieng, 1975, p. 404). Finally, a coping theory approach to understanding suicide was formulated by Mikawa (1973) who suggested that suicide should not be treated as an isolated act but cast in the framework of a process of coping with stress over time.

The above results are based on young populations or are not age-specific. In viewing coping styles over the life course, there is support for the assumption that patterns are different for the elderly. Lieberman (1975) studied 870 elderly people before and after they experienced the stress of a change in living arrangement. He reported:

1. Characteristics used to predict adaptation at other life stages are not relevant in predicting adaptation for the elderly.

2. Demanding, aggressive, irritating, narcissistic elderly individuals were most likely to survive crisis.

3. Adaptation is dependent on the cognitive and physical resources of the elderly person.

On the basis of his findings, Lieberman suggested that coping styles may be life-stage specific. This view is consistent with that of Loeb (1975) and Neugarten (cited in Bühler, 1968). Neugarten argued for the increased "inward orientation" of the aging person. She described successful aging as involving the capacity to maintain personality continuity by (a) using different coping strategies,

(b) decreasing emotional investment in the social and physical environments, and (c) increasing one's inner focus. Loeb also viewed the older person as less reliant on group and social strengths (than younger people in crisis) and, consequently, more dependent on personal resources.

The above review outlined some trends and raised questions related to how individuals cope with change. In evaluating these results, however, it is essential to be aware of the differences in coping styles among individuals. Consequently, any view of adaptation to change must consider the "variation in personal processes or style people bring to bear under crisis conditions" (Lieberman, 1975, p. 348).

Death and Dying

In this investigation, dying is defined as that part of the living process which begins when one is faced with the imminence of one's own death. By this definition death and dying are quite different phenomena. However, since the two concepts are usually treated in the literature as aspects of the same object of experience, they will be dealt with as such in this review.

An examination of the literature reveals a plethora of material on death and dying which includes a multitude of definitions and concepts. Kastenbaum (1975), for example, discussed the ways in which death can be regarded as a variable, an event, a state, an analogy and a mystery. While the above definitions are straightforward, a careful review of the literature reveals that others are more ambiguous; words with different meanings are sometimes used interchangeably. This trend is

most obvious in discussions of death anxiety and death fear, terms which are threaded through the literature and are the bases for many analyses of psychological orientations toward death. They are often regarded as synonymous terms and attempts are not made to distinguish one from the other. Therefore, it seems appropriate to examine the definitions of these basic concepts.

Death Fear and Death Anxiety

The terms death fear and death anxiety are, as indicated, frequently regarded as identical concepts, raising the question whether studies assessing them are not, in fact, assessing the same thing. This assumption is supported by a study completed by Templer (1970) in which scores on his Death Anxiety Scale correlated significantly ($r = .74$) with scores on Boyar's (1964) Fear of Death Scale. Templer referred to Boyar's instrument as "another death anxiety questionnaire" (p. 175), confirming the fact that he regarded death fear and death anxiety as the same.

Other authors have taken a more critical view of the concepts of death fear and death anxiety (Kastenbaum & Aisenberg, 1972; Kastenbaum & Costa, 1977). Kastenbaum and Aisenberg used the distinction originally established by Freud (May, 1950) and stated that "it is fear that we are experiencing if we can locate and describe the source of our concern. It is anxiety if we have a vague apprehension that something terrible is going to happen--without knowing what, where, when, why or how" (p. 55). The former state possesses direction, an object; the latter does not. Death anxiety and non-death anxiety are fre-

quently indistinguishable (Kastenbaum & Aisenberg, 1972; Templer, Lester & Ruff, 1974); this is not true of death fears and non-death fears.

The most comprehensive analysis of death fear is presented by Kastenbaum and Aisenberg (1972). Utilizing the work of Choron (1964), they identified three types of death fear--(a) fear of extinction, (b) fear of afterlife, and (c) fear of the event of dying. They then described sorrowing, overcoming and participating as additional response patterns to death, and elaborated on the conditions that enable individuals to either overcome death or develop a participatory relationship to it. One of the circumstances that increases the probability of developing an overcoming response to death is that "death is conceptualized as an external contingency" (p. 104). When death is perceived as having an internal locus, an individual is more likely to seek a participatory relationship to it. Becker and Bruner (1931) also viewed fear of death as involving several components--fears of the death of others, the effects of death, and one's own death. Despite the fact that types of death fear have been identified theoretically, they are generally not isolated in research studies. One exception to this trend can be found in the work of Collett and Lester (1969) whose instrument measures four dimensions of death fear--fear of death of self, of others, of the process of dying of self, of the process of dying of others.

Theoretical Considerations of Death and Dying

Death fear, terror of death, and death anxiety are frequently

discussed in the literature and are the focus of attention of most major personality theorists. Fromm (1964) defined the biophilous (loving life) and necrophilous (loving death) distinction as a fundamental determinant of behavior. Rank (1952) identified the birth trauma as the basis of polar forms of anxiety, namely life fear and death fear. Freud (1915/1960) described our own death as unimaginable, declaring that "at bottom no one believes in his own death" (p. 305). Feifel (1969) concluded that death is viewed as "the extreme abomination in man's experience" (p. 294). Others (Becker, 1973; Hinton, 1971) referred more specifically to the positive factors inherent in the fear of death. For example, this fear is regarded as an aid in promoting self-preservation. Hinton made reference to the biological value of death anxiety and maintained that, without it, life would be risked haphazardly and without necessity.

Despite the fact that references to death fear and death anxiety are frequently confounded with each other, some authors clearly treat death fear as a distinct and separate concept (Becker, 1973; Hutchnecker, 1959; Kastenbaum & Aisenberg, 1972; Russell, 1936/1976; Wahl, 1959; Zilboorg, 1943). Becker and Zilboorg agreed that the fear of death is universal and natural. Becker discussed two theoretical bases of the origin of this fear--that which regards it as innate and that which postulates that it is produced by the environment. Response to death fear was also addressed by these authors. Zilboorg maintained that in man's attempt to master death he denies it. In a similar vein, Becker described the paradox of the constant fear of death that exists in conjunction with conscious obliviousness to this fear.

It is apparent that authors writing from a psychoanalytic stance such as Freud, Rank and Fromm presented a theoretical view of a life-death dichotomy. Individual adjustment, in this framework, is related to which aspect of the dichotomy is unconsciously emphasized. A connection between death and the quality of life is thereby established. Another body of literature, which also connects death to life, assumes a different perspective. This connection is one in which the acceptance of the reality of ultimate death is perceived as contributing to positive emotional development. It can be found throughout literature with an existential orientation. Basically, it addresses (a) the concept of death anxiety as a motivating force, and (b) the connection between death acceptance and the manner in which the process of living is approached, handled and emotionally enhanced.

When death anxiety is discussed in the literature, it is frequently considered to be a secondary phenomenon (Feifel, 1959). However, this is not the pattern adhered to in existential thought. To the contrary, existential personality theory defines death anxiety as primary and death analysis as the most fundamental approach to understanding life (Koestenbaum, 1976). Death is regarded as the ultimate symbol of anxiety. Since high anxiety, from a psychological viewpoint, is usually treated as a negative, debilitating condition, in what manner (within the existential framework) can death anxiety function as a positive, motivating force, a facilitator of emotional growth? How is death anxiety related to life process? To provide a theoretical example of this phenomenon in the briefest, simplest terms it seems appropriate to turn to the writings of Viktor Frankl, particularly those that focus

on "will to meaning" and "pain." To Frankl, the essence of human motivation is to achieve meaning in life. In order to accomplish this, man must accept, confront, and find meaning in suffering, pain and, ultimately, in his own death (Durlak, 1972). The confrontation of negative experiences, such as anxiety about death, becomes the constructive pathway to meaning. The link between life and death is established and "death actually becomes a factor in life's meaningfulness" (Durlak, 1972, p. 463).

The facing of death, in the foregoing context, is the essence of life. In obvious agreement with this view, Kübler-Ross, Braga and Braga (1975) stated that the denial of death is partially responsible for individuals living purposeless, empty lives while acceptance of the "finiteness of . . . individual existences" (p. 164) enables them to reject extrinsic roles and expectations and move toward personal growth and development. Although the aforementioned authors reported these views in somewhat abstract terms, others are more specific in describing how confrontation of death anxiety is translated into daily living. Koestenbaum (1964/1971), for example, clearly outlined the benefits of facing the inevitability, certainty and finality of death, benefits which enable one to take charge of one's own life and to adopt a total plan for that life. In doing so one concentrates on essentials, having "once and for all conquered the ultimate threat" (p. 271).

Death and Dying from a Research Perspective

There is an implicit assumption in the literature reviewed thus

far that death anxiety and death fear are universal and are linked to the manner in which one's life is lead. Another segment of the literature describes the coping patterns that emerge in response to death. Although positive reactions such as participation and acceptance are sometimes mentioned (Kastenbaum & Aisenberg, 1972), a more popular assumption is that mechanisms such as denial, withdrawal, regression and disengagement are utilized in death confrontation (Jeffers & Verwoerdt, 1969). However, one must consider, as well, what information exists beyond the limits established by theoretical boundaries. What does the research reveal about the relationship to death? Is the strong theoretical view that death typically produces anxiety and fear supported? This review is restricted to an examination of death attitudes of adults, the population relevant to the current study, in relation to the variables of sex, age and religion.

Sex. The relationship between sex and death attitudes is frequently investigated. Several investigators have reported finding no significant relationship between these two variables. Dickstein (1978) studied a sample of 34 male and 34 female undergraduate students and reported that sex differences on four scales of death attitudes were insignificant; Feifel and Branscomb's (1973) analysis of 371 terminally ill patients revealed no significant differences in fear of personal death on the dimension of sex; Bengtson, Cuellar and Ragan (1977) studied a group of 1,221 males and females (ranging in age from 45 to 74) and observed that sex was not a significant factor in predicting death attitudes. These results are consistent with those reported by

Christ (1961/1965), Rhudick and Dibner (1961/1965), and Swenson (1961).

Another segment of the literature describes results which contradict those outlined above. Lester (1967), in a reanalysis of Middleton's (1936) data, concluded that males had a less negative affective reaction to death and dying than females but were, simultaneously, more likely to think about them. Other investigators also found differential relationships to death attitudes in males and females. Diggory and Rothman (1961/1965) concluded that women fear one aspect of death more than men, namely, dissolution of the body. They speculated this may evolve from the greater emphasis women place on physical attractiveness. Using Templer's (1970) Death Anxiety Scale, Templer, Ruff and Franks (1971) and Chiappetta, Floyd and McSeveney (1976) reported a higher manifestation of death anxiety on the part of females. Females are also described by Wallace (1976) to be more inclined than males to report wanting to die at certain times in their lives. Lester (1972) examined relationships to specific aspects of death. Using the Collett-Lester Fear of Death Scale (1969), he found women feared death of self, death of others and dying of self more than men. However, differences between men and women in other areas, such as general fear of death and semantic ratings of the death concept, were non-existent.

In summary, the results of research studies on sex differences and death attitudes yield somewhat contradictory results and are not highly conclusive. However, an examination of the individual studies reveals that differences are more likely to result when death and

dying are not defined as unidimensional concepts but are conceptualized along multidimensional lines.

Age. It has been hypothesized that death concern has continuing impact on the individual throughout the life span (Alexander, Colley & Adlerstein, 1957/1965), and that age is related to death orientation in that older people exhibit increased preoccupation with death (Jung, 1934/1959). Are these premises supported by research? Specifically, how do people view death at different points in their lives? Are death attitudes a product of age?

The results of several studies suggest there is no correlation between age and attitudes toward death. Templer et al. (1971) administered the Death Anxiety Scale to over 2,500 subjects (ages 13 to 85 years) and did not find a significant relationship between age and Death Anxiety Scale scores. These findings are consistent with those of Lester (1972), who studied 46 subjects from 17 to 50 years old, and Swenson (1961) whose sample included 210 persons who were 60 years of age and older. Christ's (1961/1965) study, with a population similar in age to that of Swenson's yielded the same results. Although these studies report consistent findings, the methodology utilized is open to question. Christ and Swenson's samples, for example, did not include an age range that was large enough to justify drawing conclusions about the age differential in death attitudes. Templer and Lester each used a single structured questionnaire, thus limiting the conceptualization of death attitudes.

Other investigators structured their studies to include a more

expansive view of the age-death attitude relationship and, thereby, contributed information on various components of this relationship. Feifel (1959) summarized the results of his studies on three groups of people--(a) 85 mentally ill patients, mean age 36 years, (b) 40 older people, mean age 67 years, and (c) 85 "normal" people divided into subgroups of 50 young people, mean age 26 years and 35 professional people, mean age 40 years. These subjects were asked to select the age period when they thought people feared death most, and feared death least. The 70's and beyond were selected by the older people and patients as the period of highest death fear because of the proximity to death. The "normal" group, however, chose the 40's and 50's since death could then not be "brushed away" and was a "definite possibility." In contrast to Feifel's older sample, Swenson (1959/1965) reported that his study (on people 50 years and older) indicated that 45% had a forward-looking attitude to death, 44% were evasive about death attitudes and only 10% admitted to fear of the death experience. A correlation between health and attitudes was an adjunct to this study. Subjects in good health were more evasive in their views of death than those in poor health who tended to look forward to it. The hypothesis implicit in Swenson's study, that death preoccupation does not increase with age, is supported by the analyses of Bengtson et al. (1977), Feifel and Branscomb (1973), and Jeffers, Nichols and Eisdorfer (1961).

While a large component of the literature is focused on the response of the aged to death, some studies deal with attitudes of the middle-aged. The confrontation of the reality of death is frequently

regarded as the dominant task of the mid-life crisis (Jaques, 1965). This observation is strongly supported by a comprehensive study by Bengtson et al. (1977) which evaluated death attitudes (expressed fear of death, frequency of thinking about death and perceived proximity of death) related to sex, race, social class and age. Their sample included people from 45 to 74 years old. One of the most salient conclusions reached by these authors was that age was the most significant factor in predicting death attitudes and that "increasing age is associated with decreased death fear" (p. 83). Subjects from 45 to 50 years old had the highest fear of death. These results were interpreted in the context of the middle-age crisis and the resolution of death fears in old age.

While most of the studies reviewed examined conscious fears of death only, Feifel and Branscomb's (1973) investigation was an exception. Using a sample of 371 healthy, physically ill and emotionally disturbed subjects, they examined response to personal death on three levels--the conscious level, fantasy notions and below-the-level-of-awareness. Age was found to be consistently related to personal fear. The authors reported:

1. Seventy-one percent of the population indicated they were not afraid of their own death. Those subjects admitting to fear were significantly younger than those who did not.

2. Fantasy level responses described a more positive perception of death by older respondents.

3. In the assessment of below-the-level-of-awareness responses,

older subjects took a significantly longer time to react to death words on a word association test than did younger subjects.

The authors concluded that responses to death fear took the form of repudiation on the conscious level, ambivalence on the fantasy level, and "outright negativity" on the nonconscious level.

The interpretation placed on the above findings is equally as important as the findings themselves. There is a trend in the literature that suggests that, with increasing age, accommodation to the death concept is attainable. In fact, in the aged population, death is considered to be feared less than prolonged illness, pain and dependency (Jeffers & Verwoerdt, 1969). Yet, denial is frequently presented as the rationale for these findings (Christ, 1961/1965; Feifel, 1959), implying that fear is perceived as the overriding "normal" response to the concept of death.

Religion. Religion has traditionally been affiliated with the death concept. Studies which report no relationship between religion and death attitudes are few (Christ, 1961/1965; Templer & Dotson, 1970). More commonly, religious beliefs are defined as avenues for coping with death fear (Feifel, 1974). However, the specific nature of the relationship between religious and death orientations is unclear. Do religious persons have a low death fear because of their faith or a high death fear which serves to intensify their religiosity (Kastenbaum & Costa, 1977)?

Feifel (1959) investigated mentally ill and "normal" people of varying ages and found religious subjects more personally fearful of death

than those who were non-religious. This trend Feifel regarded as demonstrating the need for a religious framework to cope with death fear. In a later study, religious subjects had a positive reaction to death on the conscious and fantasy levels, but exhibited increased anxiety on the unconscious level (Feifel & Branscomb, 1973). These authors concluded that "belief and faith do not seem capable of filtering their balm to deeper levels of awareness" (p. 287).

Other investigators have focused on additional dimensions of the religion-death attitude relationship. Alexander and Adlerstein (1959) assessed death responses of religious and non-religious male college students using the galvanic skin response, a semantic differential test and consciously expressed death attitudes. Similarity of responses was noted in that death was a "negatively-toned affective concept" (p. 280) for both groups. However, marked differences were displayed between the groups in the manner in which the prospect of death was handled. The non-religious group viewed death as the natural end of life; the emphasis was on life. The religious group, on the other hand, tended to keep death a conscious matter and stressed the importance of after-life. Contrary to the above results, Jeffers, et al. (1961) described clear-cut differences in death attitudes among older subjects. Lack of death fear was associated with a belief in after-life, a tendency to read the Bible frequently and death references with strong religious connotations. A belief in life after death, a literal interpretation of the Bible and strong affiliation with a religious belief system were also found by Templer

(1972) to be correlated with low death anxiety.

Some studies relate death attitudes to the specific nature of religious systems. Swenson (1961), for example, concluded that people with fundamental religious convictions and activity looked forward to death more than those with less fundamental views. Pursuing the impact of a particular belief system further, several investigators examined the relationship between death attitudes and Allport's (1968) conceptualizations of extrinsic and intrinsic religion. Stated simply, extrinsically oriented individuals use religion for their own ends. Extrinsic faith is instrumental and utilitarian. Persons with intrinsic faith find their primary motive in religion and tend to internalize their religious beliefs (Allport, 1968). Minton and Spilka's (1976) study on a sample of 73 subjects (17 to 83 years) found that extrinsic forms of personal religion correlated with eight out of nine death perspective scales in the direction of relating positively to negative death outlooks and negatively to more positive ones. Intrinsic religious orientation was significantly and negatively correlated with death fear for a sample of 70 Catholics, Baptists and Methodists (Kahoe & Dunn, 1975). Everts (1978) examined a group of people who were more intrinsically religious, self-actualized and reported less death fear than control subjects. His results supported those of Feifel and Branscomb (1973), namely, that regardless of reported death fears, fear of death is similar on less conscious awareness levels.

It is obvious that an examination of the research does not result

in a clear definition of the relationship between death concern and religion. A reasonable conclusion is that while not all religious systems serve to reduce death fears, some are effective in this area. Criticism is directed toward research on this topic in relation to the samples studied, the measurements utilized and the generalizations drawn from the findings (Martin & Wrightsman, 1964). Additional confusion seems to evolve from the assessment of both conscious and unconscious levels of death awareness in the context of varying definitions of religiosity. Those studies that divided religion and death attitudes into meaningful sub-categories and explored the relationships among them (Vernon, 1970) seem to have contributed the most relevant information on the question of how death attitudes and religion are related.

Dying

The process of dying has recently emerged as a subject of study. Interest in the area is mounting, and some proclaim that "the plight of the terminally ill person has become the central focus of the current death awareness movement" (Kastenbaum & Costa, 1977, p. 241).

A stage theory approach to dying has commonly been used in analyzing the dying process. In his discussion of trends exhibited by cancer patients, Weisman (1972) outlined three stages, each involving different degrees of acceptance and denial.

1. Denial and postponement. Patients combine an "out of sight, out of mind" philosophy with increased vulnerability.

2. Mitigation and displacement. Denial and acceptance shift

and the realities of illness are confronted. This stage includes three response levels that Weisman labelled initial, intermediate and pre-terminal responses.

3. Counter-control and cessation. Patients relinquish choice and control to others.

Kübler-Ross (1969) popularized the stage theory of dying and based her conclusions on interviews with over 200 terminally ill persons. The stages she defined are reflective of the coping mechanisms utilized in reaction to terminal illness.

1. Denial is interpreted as a temporary defense which serves the adaptive function of a buffer, providing patients with time to collect themselves and assume less radical defenses. It is characterized by the attitude, "No, not me, it cannot be true."

2. Anger as well as rage, envy and resentment directed randomly toward the environment dominates this stage. The question "Why me?" typifies patients' world views.

3. Bargaining. Attempts are made to make a deal with fate, God or members of the environment. "Good behavior" is promised in return for a postponement of death.

4. Depression emerges when patients can no longer deny their illnesses, when physical symptoms increase. It is regarded as a preparation for the impending loss with which patients are confronted and for the onset of the final stage.

5. Acceptance. Patients are no longer angry or depressed at this stage and are almost devoid of feelings. Acceptance will evolve

if the "patient has had enough time . . . . and has been given some help in working through the previously described stages" (Kübler-Ross, 1969, p. 99).

Concurrent with her emphasis on understanding dying patients, Kübler-Ross provided suggestions on how they could best be helped at each stage. She also stressed that threads of hope exist throughout the dying process. They function to maintain terminally ill patients "through days, weeks, or months of suffering. It is the feeling that all of this must have some meaning . . . . It gives the terminally ill a sense of mission in life which helps them to maintain their spirits" (Kübler-Ross, 1969, p. 123).

Kübler-Ross' (1969) contribution has been applauded for its focus on a previously taboo topic, its recognition of the emotional needs of the dying person, and for its systematic description of the dying process (Kastenbaum, 1975). However, widespread criticism has also been directed toward her work (Kalish, 1976; Kastenbaum, 1975; Kastenbaum & Costa, 1977; Schulz & Aderman, 1974). Kastenbaum (1975) and Kastenbaum & Costa (1977), for example, criticized (a) the poor definition of the stages, (b) the fact that variables (such as nature of the disease and treatment, sex differences, ethnicity, personality and cognitive style, developmental level and sociophysical environment) are not taken into consideration, and (c) the lack of evidence to support the assumption that each person moves through all of the stages.

Following a review of the research, Schulz and Aderman (1974)

also concluded there is no support for the assumption that dying patients pass through predictable stages. Yet, Kübler-Ross' work has been highly influential and commonly applied as a guideline in contact with the terminally ill. Kalish (1976) posited that "adequate" styles of coping with dying are frequently measured in the framework of the stages and, consequently, "are in danger of becoming self-fulfilling prophecies" (p. 94). The logical outcome of such a trend would be toward promoting an adjustment to the "norm" and away from recognition of the individual needs and personal response patterns of terminally ill people. In summary, the stage theory as presented by Kübler-Ross is regarded by most critics as an over-simplified view that draws generalizations from subjective interpretation and does not adequately examine dying persons in the context of their current situation and previous life (Kastenbaum & Costa, 1977).

Those studies that objectively evaluate the dying process are few. One of the most comprehensive studies in this area was completed by Hinton (1963). He assessed the mental status, personality history and physical discomforts of 102 patients who were expected to die within six months, and compared them to a matched control group of patients who were seriously, but not fatally ill. The study produced results that consistently differentiated the responses of the terminally ill patients from those of the controls. Physical distress was experienced more frequently by dying patients who also had significantly higher levels of depression and anxiety. Additional information on the latter finding was contributed by Kastenbaum and

Aisenberg (1976) who further analyzed Hinton's data. They found that dying patients were more depressed than anxious, and concluded that depression was the more prominent differential. Hinton's results indicated, as well, that (a) depression and anxiety were more common in patients who were aware they were dying, (b) dying patients under 50 years of age displayed the highest degree of mental and physical distress, (c) anxiety was more prevalent in those dying patients who had dependent children and a weak religious faith, and (d) increased impairment of consciousness occurred in patients who were dying.

The fact that psychological changes occur prior to death is also supported by Lieberman's (1965) study on aged subjects who were administered four psychological tasks over a two and a half year period. He divided his subject pool into a Death-Imminent group (eight subjects who died less than three months after completing a minimum of five testing trials) and a Death-Delayed group (17 subjects who were still alive after they had completed at least 10 trials). In summary, the former group changed significantly in the direction of less adequate performance on the psychological tasks. The author interprets this as reflecting a decrease in the "capacity to cope adequately with environmental demands, particularly because of the lowered ability to organize and integrate stimuli in the environment. The primary subjective experience is one of chaos" (Lieberman, 1965, p. 190).

On the basis of Lieberman's and Hinton's studies, one can conclude that closeness to death is associated with changes in psychological functioning. Do other investigations support this assumption and, if

not, what is the predominant affective reaction to one's own dying process? Kastenbaum (1967) studied 61 terminally ill people using the psychological autopsy method of analysis. In this population of 31 men (with a mean death age of 82.8 years) and 30 women (with a mean death age of 81.7 years) a high quality of mental functioning was maintained, and positive references to one's own death were made much more frequently than negative ones. Another well organized study, completed by Cappon (1959), also found that personality changes do not take place during the dying period. Using 19 terminally ill patients and seven control groups, he interviewed patients and obtained fantasy material at sleep and waking levels of awareness. Fear was not prevalent in Cappon's sample of dying patients; hostility was a more common reaction. The latter finding is consistent with that of Duke (1978) who found terminally ill people to be denying, angry or depressed.

Research on dying has been approached in an obviously unsystematic fashion. Although Kübler-Ross' work represents an attempt to examine the dying process more thoroughly, the literature does not lend strong support to the validity of her conclusions. Some research difficulties in this area seem to evolve from the populations used. Geriatric subjects are most frequently studied, and thus the response repertoire to dying may be influenced by the narrow age range represented. Finally, there appears to be no consistency in reactions to dying. Psychological deterioration, mental stability, depression, acceptance, anxiety and anger are among the responses described. Perhaps attention to Cappon's (1959) conclusion, that "men die as they

lived, beset by abnormalities of character and mood" (p. 467) would contribute a dimension worthy of closer examination.

An Integration of the Literature

Theoretical views and research results on the unified character of personality, the nature of change, and the relationships of individuals to death and dying have been examined in the foregoing section. Trends in specific directions can be extracted from some aspects of the material. However, uniformity of agreement does not exist in other areas, thus raising questions that are left open to consideration.

There is little question that, from popular theoretical viewpoints, personality can be defined accurately as a consistent, patterned unit that has the capacity to accommodate to change. How this accommodation takes place and how, specifically, change is conceptualized are less clear. For example, theorists that (a) favor a stage model of development, or (b) view homeostasis as the basic motivating force, or (c) emphasize the drive toward growth and change, all provide a different rationale for the basis of change and how individuals adapt to it. A higher level of agreement exists, however, on the definition of change events as experiences of disequilibrium that are not resolved by the usual modes of behavior. Crisis theorists are outstanding in their view of crisis (a specific form of change experience) as possessing circumscribed time restrictions.

The questions of whether confrontation with dying is a change experience and how people respond to it are basic to this investigation. However, the literature on death and dying, although extensive, does

not provide consistent responses to these questions. The literature is further confounded, in this investigator's opinion, by (a) the common view of death anxiety and death fear as identical concepts, and (b) the tendency to view death fear as universal. Some of the more specific trends that evolve out of the research are related to the variables of age and religion. There is support for the assumptions that certain, although not all, religious orientations tend to reduce death fears and that expressed fear of death tends to decrease with age. Further, reactions to dying are not described consistently and the literature in this area does not yield consistent results.

The contradictory research results in studies related to death and dying may, partially, be related to the problems encountered in research methodology. Jeffers and Verwoerdt (1969) defined these as (a) the difficulties in arriving at suitable operational definitions, (b) the utilization of diverse subjects and instruments that make comparison of results difficult, and (c) the fact that existing scales are judged to be inadequate to measure degrees of death awareness and the meaning death holds for different individuals.

Having considered the areas outlined above individually, how are they interrelated? Is dying approached in a manner consistent with that generally utilized in coping with change? Can, in fact, dying be defined as a change event? Throughout the literature death and dying are regarded as crises. However, another viewpoint places the determinant of adjustment to both death and dying in the context of one's total life experience--i.e. the manner in which persons

have adjusted to changes and crises in their past life (Jeffers & Verwoerdt, 1969). Similarly, Kastenbaum (1975) made a case for the inappropriateness of the assumption that either death or dying can universally be treated as crises. Maintaining that dying may or may not be a crisis, he posited that the general laws of personality governing a particular individual continue to hold true when that individual is dying. He, therefore, concluded that sensitivity to the needs of the dying person "without imposing a ready-made theoretical orientation" (p. 48) should be a priority.

CHAPTER III

METHODOLOGY

Procedure and Design

Sample

Pilot study. A pilot study was conducted to assess the efficacy of the semi-structured interview. Six persons were interviewed; five were currently receiving (or had received) treatment for cancer and one had come close to dying from an intestinal disease. One of these subjects was known to the investigator, three were referred by individuals known personally to the investigator and two were referred by other pilot study subjects. Two of these subjects (15 and 16) were ultimately included in the main study. The interview format used for these subjects was identical to that used with the subjects in the main study.

Subjects. Twenty-one subjects (10 males and 11 females) were interviewed and 17 of these subjects were administered the Living-Style/Dying-Style Questionnaire. All subjects were currently (or had been) faced with a life-threatening illness. All had viewed themselves as dying at a point in their lives or regarded themselves as dying when the interview took place.

In addition to the twenty-one subjects, four others were interviewed. Due to technical problems (a faulty tape) and the unsuitability of three subjects for the study (one refused to respond to the interview format and two did not perceive their illnesses as life-threatening), the data obtained could not be analyzed.

Procedure

The City of Edmonton Home Care Services program was the formal referral source for the subjects. Prior to the agreement to provide referrals, the investigator submitted a copy of the research proposal and interview outline to the director of the Home Care Services program and subsequently met with its research evaluation committee to discuss the study and the mechanics of the referral procedure. It was agreed that a consent form would be utilized in which subjects would (a) voluntarily agree to participate in the study, and (b) give permission to the investigator to communicate information to the Home Care case co-ordinator if deemed necessary (Appendix A). The investigator also agreed to make available, in the form of a verbal presentation, the results of the study to the Home Care Services staff members. These agreements were confirmed by letter (Appendix B). At a later point, a structure was established in which clearance was obtained from subjects' respective doctors prior to the interview (if they were Home Care Services referrals and were in an active treatment program at the W. W. Cross Cancer Hospital).

In addition to the seven Home Care Services referrals, subjects were obtained from several other sources. Two were referred by a Home Care Services worker who knew the subjects personally, nine were referred by other subjects who had already been interviewed, and three were contacted through personal and professional connections of the investigator. A separate consent form was used for those subjects who were not involved with Home Care Services (Appendix C).

Contact with all subjects was initiated by telephone. In some cases the subject had already consented to participate in the study in discussion with the Home Care Services worker. A phone call was then made to confirm these plans and set up an interview appointment. If this had not been done, an introduction was made by telephone. The nature and purpose of the study and the person who had provided the subject's name was established. Subjects were then given the leeway to ask questions and the option to choose to participate or not participate in the study. No subjects declined to participate in the study when they were contacted by the investigator. (Two who initially agreed to be interviewed were later judged to be too ill to proceed and four more potential subjects chose not to participate when initially approached by others). Arrangements were then made for the interview; the place of the interview was left to the discretion of the subject. Eleven subjects were interviewed in their homes, six at their places of employment, and four in the investigator's office. All subjects, with the exception of subject 1 were interviewed once. Since she was in a weakened condition, she was seen for two 45 minute interviews.

Instruments

Interview schedule. An open-ended, loosely structured interview schedule was initially formulated by the investigator for use in the pilot study. It was modified in the early stages of the pilot study.

A semi-structured interview schedule was then designed (Appendix D) to determine patterns of coping with life-change experiences and the

threat of dying (generally and in the context of Keleman's (1974) description of eruptive and congealing response patterns). Questions were designed to (a) elicit the most descriptive information on change experiences, and (b) encourage subjects to discuss life-threatening illnesses and confrontation with dying in the least threatening way possible. Consequently, the interview schedule did not follow a strict "question-answer" format. All subjects were asked the specific questions relevant to the study; however, they were also given the freedom to describe change experiences in their own ways and were encouraged to elaborate on their respective descriptions.

During the pilot and main studies the interview schedule was reviewed and critiqued by members of the investigator's thesis committee. The tapes of entire interviews (during the pilot study) and segments of interviews (during the main study) were evaluated by committee members for interview approach and content.

The interviews proceeded according to the following format:

1. After an initial introduction, a general statement about the nature and purpose of the study was made (Appendix D, #1) at which point respondents were provided with assurance of confidentiality and asked to sign the consent form.

2. Factual data about the respondent were then collected.

3. Respondents were asked to describe change experiences in the order that they chose (Appendix D, #2). This structure was established to maximize respondents' level of comfort.

4. If terminal illness or dying was not identified as an ex-

perience of change by the end of the interview, the investigator asked questions related to these areas (Appendix D, #4).

5. Additional information and/or clarification was requested when deemed necessary by the investigator.

6. Each interview terminated with request for respondent feedback on the interview.

7. Each interview was tape recorded.

The question of the validity of the information obtained from the respondents was considered by the investigator. The respondents' self-perception of response to change was regarded as a crucial component of this study. In studies of this kind, whether or not the self-description and the actual circumstances of the event are congruent is frequently left open to question. However, even in instances in which they are incongruent, Becker (1958) stressed that the observer can still interpret such descriptions and statements as "indications of the individual's perspective on the situation" (p. 655) and thereby obtain important information. Becker emphasized, as this investigator did, the significance of the respondents' view of the event and resulting behavior (as opposed to an accurate, factual depiction of either). Secondly, Becker concluded that volunteered statements, such as were frequently obtained in the current investigation, were least likely to reflect "observer's pre-occupations and possible biases" (p. 655) and were, therefore, more inclined to be valid.

The main purpose of the present study was to describe the dying process as seen by people who were going through it. Since past

counselling experience suggested that there would be individual differences in the ways that people deal with their own inner feelings, thoughts, etc., a research methodology was chosen that would accommodate as much as possible to these differences while, simultaneously, obtaining the desired ends. The researcher was the "instrument" of the study, and the validity of the information obtained was dependent on her clinical skills. Some evidence concerning the validity of those skills is provided through the resume of work experience and academic qualifications included in Appendix E.

The positive rapport judged to exist between the investigator and the respondents was also regarded as a basis for the credibility of the information provided. In addition to the investigator's subjective impressions, the conclusion that good rapport was established was based on (a) the number of referrals (nine) initiated by subjects who had already been interviewed, and (b) the positive feedback statements. For example, subject 9 said that the interview "has done me a lot of good." Subject 13 maintained "this interview impressed me in the sense that it gave me another opportunity to think about my situation" while subject 15 stated: "I thought I might be giving you some dumb answers but I think it's good. I think it's good to go over the good and bad things of the past because they all help to make you what you are today." Providing another perspective, subject 20 concluded that the interview forced him to think back to the way he felt during change events. "I think, too often, we remember things but we don't remember our reactions to them and I

think it's important to do that." Finally, subject 3 confirmed that he had been as "up front" as possible. In summary, the above respondent reactions coupled with the numbers of referrals and the fact that all respondents agreed to voluntary participation in the study lend support to the credibility of the information given.

Living-Style/Dying-Style Questionnaire. This questionnaire (hereafter referred to as the LS/DSQ) was designed by the investigator. It was based on Keleman's (1974) descriptions of eruptive and congealing response patterns and was formulated in accordance with the following procedure:

1. A written description of Keleman's (1974) concepts of eruptive and congealing patterns of living and dying was presented to 15 persons (counselling psychologists, Masters and Ph.D. students in a counselling psychology program). Each person was asked to provide paired adjectives or phrases that were descriptive of the respective patterns (Appendix F).

2. The descriptions were reviewed by the investigator and those on which there was frequent agreement were used to develop the LS/DSQ.

3. The LS/DSQ contains 25 items and is divided into two separate, identical parts on which subjects were asked to rate their behavior (on a scale of seven) in relation to change experiences that (a) were not related to terminal illness or dying, and (b) were related to terminal illness and/or dying (Appendix G).

4. Each item was keyed as eruptive or congealing on the basis of the initial descriptions provided (Appendix H).

5. The LS/DSQ was scored by omitting all mid-range (4) responses. Responses one through three and five through seven were then scored as eruptive or congealing, depending on how the item was keyed.

The LS/DSQ was administered to 17 of the 21 subjects. It was not administered to the two pilot study subjects (since it was not then available in its final form). One subject was too ill to complete it and another refused to take it. Part A was administered first, followed by Part B.

This questionnaire was designed to (a) obtain information (beyond that which was presented in the interview) about respondents' perceptions of how they responded to change, and (b) determine whether this information was consistent with the interview material. A secondary function of the LS/DSQ was to ascertain whether the categorization of eruptive and congealing response patterns was a useful one in assessing reactions to change and what, if any, behavioral descriptions and attitudes were associated with these categorizations. No statistical pre-assessment of the questionnaire was undertaken, since it was not intended for use as a measure of an underlying construct.

Definitions Used to Guide the Research

Life and Death

Life and death are states.

Life is the state of being independently biologically alive. Life begins with birth and ends with death.

Death is the final cessation of vital functions, the cessation of life, the termination of life.

Living and Dying

Living and dying are processes.

Living is the continuous process which extends through life, from birth to death.

Dying is part of the living process in which one is faced with an experience of change. For the purpose of this study, dying is defined as beginning when one is faced with the imminence of one's own death.

Terminal or Life-Threatening Illnesses

Terminal or life-threatening illnesses are those in which the diagnosis is such that the threat of dying is a reality and the individual is aware of this reality.

Change Experiences

Change experiences are those in which (a) there is a quality of disequilibrium, and (b) there is a subjectively described shift in one's life in which identifiable relationships (personal or material) are altered or severed.

Eruptive and Congealing Response Patterns

These definitions are based on those established by Keleman (1974).

Patterns were considered to be eruptive if subjects extended themselves into the social world, utilized interaction with others in the change experience, and emphasized the external components of the change experience (i.e. external practical aspects).

Patterns were considered to be congealing if subjects had a higher level of contact with self than the external world, if privacy

characterized their responses to change and if the internal reaction to change experiences (i.e. withdrawing, sorting it out on one's own) were dominant.

Analysis of Data

Recorded tapes were analyzed for demographic information, descriptions of change experiences, and response patterns in coping with change. When all the interviews had been completed, each tape was played back in its entirety, and thorough notes were taken on each tape. A case summary was then written on each subject.

The LS/DSQ was analyzed in the following way:

1. Subjects' scores on individual items were evaluated.

2. An examination of whether total responses fell into eruptive or congealing categories was completed.

3. The relationship between responses on the two parts of the LS/DSQ was evaluated.

CHAPTER IV

RESULTS

In many respects, the study was made up of 21 case studies. Each interview was examined separately to identify individual patterns. Since each subject was important, the case descriptions are presented in the body of the thesis. Demographic summaries of age (Table 1) marital status (Table 2), educational level (Table 3) and religious affiliation (Table 4) follow the case descriptions.

Case Descriptions

Subject 1

Female, age 65.

Married, has one son, three grandchildren.

Completed grade 8.

Father died when subject was an infant. There were three children from this union. Her mother remarried and there were more children from this relationship.

She worked for 14 years as a hospital porter, ward aide and filing clerk. She also worked part-time in a home for the aged.

She belongs to a German Church of God. She was active in church prior to her illness. She became a "real Christian" in 1943 and believes in after life, "a heaven to gain, a hell to shun."

She was diagnosed as having lung cancer in 1978. She described her condition as "terminal cancer."

Change Experience #1 - the stressful situation she experienced while working at the hospital.

Change Experience #2 - when, as an adolescent, she believed her family regarded her as unattractive, an "ugly duckling" and felt this way herself.

Change Experience #3 - when she became a "born again Christian" in 1943.

Dying is not defined as a change experience by this subject since she knows she is "born again" and has a "place prepared for me."

External responses and structure define for this subject her feelings about herself and her mode of behavior. This is apparent in the coping style described in relation to change experiences #1 and #2 (in which employers' positive feedback and adolescent boys' attention to her had personal significance as well as impact on her behavior). The trend toward reliance on the external is also evident in her descriptions of how the tenets of Christianity defined her mode of life (i.e. being more caring, loving, giving, growing "in grace"). Her manner of handling change experiences is consistent--working harder, trying harder, conforming to expectations, never rebelling. The latter is a particularly strong theme expressed throughout the interview. Dying, for this subject, is not viewed as a time of change because in her religious framework, life will continue in another form and she is prepared to accept God's plan for her.

Subject 2

Female, age 62.

Married, has two children.

Completed the equivalent of a grade 12 education in another country.

She is the eldest of five children. Her parents both died of cancer.

She belongs to the Roman Catholic religion and describes herself as "vaguely active" prior to her illness. She believes in after-life.

Diagnosed as having cancer seven years ago. In the last five years she has had a lot of surgery and radiation treatments. Her case was closed at the Cancer Hospital six months ago. To her, this was the end of "earthly treatment" as far as medicine could go.

Change Experience #1 - this current period of illness in which she is getting progressively more tired and weak and finds it impossible to lead a "normal life."

Change Experience #2 - the period following her colostomy (two years ago).

Change Experience #3 - when she moved from her native country to Africa.

Change Experience #4 - when she returned to her native country with a new baby and lived for alternate one week periods with her parents and in-laws.

Change Experience #5 - her move to Canada.

Passivity is the primary theme in this subject's response to change experience. This is reflected, for example, in her desire to please her parents and in-laws at the expense of inconvenience to

herself (change experience #4), her handling of her illness in a way that will create the minimum amount of difficulty for others (change experience #1). In addition, her coping with change is unequivocally on the level of the concrete, practical and private. These patterns are also reflected in attitudes toward preferred form of dying which, if the subject had her way, would be alone, in her sleep, and rapid. She would consider suicide if it was offered in the form of an "extra needle at the end" but would not initiate it herself.

Subject 3

Male, age 46.

Married, has three children.

Completed grade 12.

He is the eldest of five children. His mother is alive, father is dead.

He is employed in the communications industry.

He attends the United Church but describes himself as an inactive member of the religious community (even though he participates in church activities). He has his own interpretation of religion. His belief in after-life is not strong although he thinks the soul goes "somewhere" after death.

He was diagnosed as having lymphoma (a form of leukemia) in 1978. It was described to him then as being "quite advanced and serious." He is on chemotherapy and says he has "bounced back." He regards himself as more healthy than unhealthy and as "realistically hopeful." He says having cancer has been traumatic but "by the same token I

haven't given up."

Change Experience #1 - has two parts, (a) his move to Edmonton 25 years ago evolving out of his relationship to a woman who moved here, and (b) the subsequent termination of that relationship.

Change Experience #2 - the emotional upset (coupled with high blood pressure) that accompanied his entering his 40's, the fact that he was overextended on his job and was questioning what he was doing with his life.

Change Experience #3 - when the diagnosis of cancer was made and he viewed himself as dying.

This subject has dealt with change experiences in his life in concrete, practical ways, essentially, coping with each situation on his own. He has relied heavily on his own resources and views himself as coping most successfully when concrete action is possible. The emotional experience described in change experience #2 is described as being highly stressful (and was one in which practical, specific solutions were not immediately available). In fact, the emotional stress in this experience is reported to be greater than in change experience #3 in which he was confronted with cancer and the possibility of dying. Although he is very verbal about his illness and discusses attitudes toward dying freely, he basically is dealing with it privately, making deliberate attempts to be positive about his life. In his view, this will provide him with the optimum chance of conquering his illness. This can be interpreted as an example of taking a specific mode of action to obtain desired results, in this

case maintaining a "proper frame of mind" since if his illness "preys on the mind then it's going to get me." There is also indication that the illness has served to encourage him to evaluate his priorities and, consequently, attempt to get more "living" out of life.

Subject 4

Female, age 65.

Single.

She has a B.Ed. and a music degree.

She was a school teacher who last taught in 1975.

She is a member of Moral Rearmament which she describes as an idea in action. She states that God can speak to her through her inner voice. She has been affiliated with this movement since she was 18 years old. She believes in after-life, feels that "life is eternal," but doesn't know what form after-life will take.

She is in the advanced stages of lung cancer and doesn't know what the prognosis is. She states the "doctors won't predict for me anymore."

Change Experience #1 - when she joined Moral Rearmament, an act which she feels charted the course of her life.

Change Experience #2 - when the initial diagnosis of cancer was made.

Change Experience #3 - when, as a child and adolescent, she was so hard to handle her parents didn't know what to do with her and "gave up" on her.

The theme in this subject's orientation toward change is that her religious belief has consistently channeled her course of action. The single exception to this is change experience #3 (rebellion as a child and adolescent) which she ultimately resolved by deciding to join Moral Rearmament, an act that "set things right with my parents." The belief in Moral Rearmament has defined her behavior and values and provided a framework within which she operates. It has, she believes, led her up certain pathways through life (i.e. choosing teaching as a profession). She has placed every situation in "God's hands" and believes that all she needs to do is "continue to get direction day-by-day." Consequently, dying is not viewed by this subject as a potentially stressful situation but she looks "forward to it as a great adventure." Since life is "eternal" she believes that her life will be sustained in some form after death.

Subject 5

Male, age 42.

Married, has two children.

Completed grade 12.

He is the youngest of two children. His mother is divorced and remarried. His step-father is dead and he has no contact with his natural father.

He is employed as an office worker.

He has no religious affiliation or belief in after-life.

He had an inoperable malignant brain tumor (which was initially diagnosed as multiple sclerosis in 1959) and was diagnosed accurately

in 1964. He was then given two years to live. He was given cobalt treatment and is no longer under treatment. He considers himself cured.

Change Experience #1 - the stress relating to the problems in his first marriage, the separation and period following the separation.

Change Experience #2 - the death of his grandfather (when the subject was 19 years old).

Change Experience #3 - when the subject was diagnosed as having multiple sclerosis.

Change Experience #4 - when he learned (through his mother) that he had a brain tumor and believed he was going to die soon.

The pattern exhibited by this subject in dealing with change experiences in his life is highly consistent. In each instance he withdrew from others, was depressed, attempted to relieve his depression by drinking and describes intense feelings of loneliness and isolation. The single exception to this was change experience #2 in which sorrow and guilt were the primary feelings. All experiences were dealt with without the support of others. However, he ultimately made some attempts to relieve his depression by becoming more involved in his work, contacting other people. However, none of the latter instances can be classified as close, intimate contact.

The consistent thread in this subject's pattern is that he is a loner, an introvert (words he frequently used to describe himself). The initial responses to both diagnoses adhere to the pattern described above. However, in the case of the brain tumor, there was some

expressed relief because he viewed the tumor as concrete (a perception he did not have of MS) and states: "I got stubborn and just figured I'm going to lick this" (which he believes he accomplished). At this time he doesn't think about dying and expects to die of a stroke at 95. If he could choose his mode of dying it would be alone.

Subject 6

Female, age 61.

Divorced 20 years ago, has three children.

Completed grade 8.

She is the eldest of four children. Her parents are dead.

She worked on a farm and operated a country store when she was younger.

She was raised Catholic but rejected Catholicism. She believes in God but doesn't have strong affiliations with any church. She isn't certain about after-life but believes she will be held accountable to a loving God for her life on earth.

She has had rheumatoid arthritis for over 30 years which she describes as "getting worse all the time." She recently had pneumonia and almost died.

Change Experience #1 - the break-up of her marriage when her husband left her for another woman.

Change Experience #2 - when she was first married (at age 18).

Change Experience #3 - the financial stress related to the move from a rural community to Edmonton.

Change Experience #4 - when she was in hospital several months ago, was very ill and came close to dying.

Change Experience #5 - when she had three operations on her knee in seven months and was in a great deal of pain.

The change experiences described by this subject are negative (with the exception of change experience #4). Emotions such as anger, feeling deceived, being upset are associated with them. However, some (change experience #'s 2 and 3, in particular) are more stressful in retrospect in that she didn't realize the impact of them until they were over. She handled them, generally, by hard work, doing the best she could under adverse conditions, and coping basically on her own. She describes herself as a "loner," a "go-getter" and "bull-headed." There is a feeling of pride associated with having coped with stressful life situations successfully. ("It made a better person out of me. We survived. That's what we did. We survived! I always managed to crawl through somehow.") Change experience #4 has a different tenor. When she felt she was closest to dying she describes herself as contented, as being at peace with the world and reports that after this "turning point" she got better. She states she has no fear of dying and views herself as being ready to die. Although she doesn't expect to die peacefully, she would like to die peacefully and alone. She also feels strongly that she has the right to take her own life if she chooses.

Subject 7

Female, age 67.

Widowed; husband died 12 years ago. She has two living children. A son died seven years ago.

Education equivalent to one year of university (normal school).

She is the fourth youngest in a family of 10 children. Her parents are both dead.

She taught school for twelve years (prior to her marriage) and for three years (after her husband's death).

She attends a Ukrainian Orthodox Church but views herself as having a personal (as opposed to formal) belief system. She is inactive in the religious community. She believes in after-life and thinks there is "some other level of life before we're ready to go on to the final place."

She has cancer of the spine and hips which was originally diagnosed in 1975. She is on chemotherapy.

Change Experience #1 - living through World War II while her husband was in the Armed Forces. At this time she had been married for six months.

Change Experience #2 - when she taught in a rural school after finishing normal school (at age 19).

Change Experience #3 - the death of her son.

Change Experience #4 - the death of her husband from cancer six weeks after the diagnosis was made.

The feelings associated with change experiences in this subject's life are negative--desperation, anger and loneliness. She handled each experience by hard work, coping the best she could and, in the case of her husband's and son's deaths, returned to work to keep herself occupied. Generally, she did not express her feelings to others, put up a good front and tended to sort out each experience on her own. Having cancer is not identified as a change experience by

this subject. It has not had the same emotional impact as the other experiences and the only thing she fears in it is the potential for physical pain. She attributes the onset of cancer to stress in her life (particularly the death of her son to whom she was very close). She is handling her illness by living her life "a day at a time" and maintains that she doesn't "mind one little bit" when she thinks about the possibility of dying.

Subject 8

Female, age 71.

Widowed since 1964, has three children.

Education equivalent to second year university. Attended normal school.

She is the eldest in a family of four children. Her mother also had cancer.

Taught school for 36 years.

She describes herself as a "Christian" with strong religious beliefs. She attends a Pentacostal Church but isn't a member. She has a definite belief in after-life in which the "spirit goes back to God who gave it." She also thinks there is a "place of punishment" for those who don't believe.

She has cancer, had a mastectomy and states the cancer has spread to her liver. She has had radiation treatments for growths in her neck and is now on chemotherapy. The initial diagnosis was made two years ago. She states she is getting little information from her doctors and is annoyed since she wants to know "what is ahead of me."

Change Experience #1 - her father's sudden death (when she was 14) followed by her mother's illness with cancer. For an extended period the subject, a hired hand and the subject's siblings ran the farm.

Change Experience #2 - after she had been married for eight years, had two young children, her husband was ill and she was "worn out and broken" from running the farm. So, she chose to return to teaching which involved a move for the family to another rural community.

Change Experience #3 - the struggle around her decision to move from her condominium to a Senior Citizens' Home.

Change Experience #4 - when she was diagnosed as having cancer and faced the possibility of dying.

This subject has approached each change experience "head on," without giving much thought to the basis for her behavior in any given situation. She views her life as having been difficult, involving a great deal of hard work. However, she describes herself as an aggressive person with a lot of pride who always welcomed challenges. There is also an expressed sense of pride for having survived hardship as well as she did. Each experience has been a "private" one for her and she is dealing with her cancer in a similar way, maintaining she wants to handle it on her own. She does not view herself as having had the capacity to do anything differently in any change experience since she was in a "groove." While the subject describes herself as having strong religious beliefs, they

do not dominate her life in a manner that clouds her strong personal opinions. For example, even though she knows her cancer is progressing, she would prefer not to die since leaving her family will be difficult. For her children's sake, too, she would choose to die alone, in the "middle of the ocean where nobody would ever see me again."

At the termination of this interview, this subject said she had never, in her life, thought about the kind of person she was and asked for a copy of the tape so she could learn about herself.

Subject 9

Female, age 59.

Married, has one child.

Completed grade 12.

She is the youngest of two children. Both parents died of cancer.

She worked part-time (for a total of five years) doing secretarial and sales work.

She describes herself as Protestant but doesn't go to church. She doesn't know whether she believes in after-life.

She has cancer in her kidneys, bone marrow and breast which was diagnosed five months ago. She is being treated by chemotherapy. Her view of her prognosis changes from day-to-day. She doesn't know what to think but reports the doctors say she has from eight to 10 "good years."

Change Experience #1 - when she fell, broke her arm and shoulder and, subsequently, discovered she had cancer.

Change Experience #2 - when her husband almost died of an ulcer attack 17 years ago (as well as the period leading up to it when he was very ill).

Change Experience #3 - when her mother came to live with her and stayed for 18 years.

Change Experience #4 - when her father died. Part of the difficulty in this experience was related to the fact that it was "rough" on her husband.

All the change experiences in this subject's life are negative. Feelings associated with them are also negative--being worried, anger, bitterness, sadness. She tended to deal with them by being overtly accepting in a passive way and covertly resentful (with the exception of change experience #1 in which resentment was openly expressed). Many regrets are expressed about the manner in which she lived her life. The primary theme is related to the constant nurturing, caring, selfless role she carried in relation to other people. In retrospect, she would do things very differently. How she would be different is summed up in her statement concerning change experience #2-- "I think I was a very foolish woman. . . I was kind of wishy-washy. I'd be a lot more positive about what I wanted and didn't want and I just wouldn't let people walk on me." She felt she wanted things to change throughout her life but felt powerless to execute change. In her illness the lack of energy and activity is the most difficult adaptation to make. She expresses no fear of dying but, again, her major concern is what would happen to her husband if she dies.

Subject 10

Female, age 49.

Married, has five children.

Completed grade 9.

She is the eldest of two children. Her father died of cancer, her mother is still alive.

She has worked sporadically in unskilled jobs.

She is Roman Catholic, inactive in church activities and states she goes to church "sometimes." She describes herself as not "really, really religious." She doesn't know whether she believes in afterlife.

She has cancer of the uterus which was diagnosed several months ago. It has spread to the bowel and she has been treated with surgery, radiation, and chemotherapy. She states that the doctors are hoping the chemotherapy and radiation will make her "all right." She isn't sure that will happen.

Change Experience #1 - adjustment to married life, closely followed by adjustment to motherhood.

Change Experience #2 - stress during childhood when mother periodically deserted the family and left permanently when the subject was an adolescent.

Change Experience #3 - stress evolving out of problematic relationship with her husband.

Change Experience #4 - the period since she has known she has cancer.

The pattern demonstrated by this subject in dealing with change experiences is clear and consistent. In her view they are all negative with feelings such as loneliness, anger, hatred (toward her mother), resentment associated with them. There is also a trend toward having the most intense feelings in the early stages of each experience and, then, giving in to the situation in a superficially passive way. For example, in referring to her relationship with her husband (change experience #3), she maintains that "There's no sense of fighting . . . You can't talk to him. . . I've got to do what he says." She has basically handled change on her own, regards each change experience as "private." The pattern described above is also apparent in her relationship to her cancer. When interviewed she indicated she had been more upset when the diagnosis was first made. Now, she accepts the possibility of dying and would "just like to lie there in peace and not go through all this suffering I am." The cancer is obviously viewed as one more experience of suffering in a life of suffering. In her words, "The way I look at it, if I went tomorrow I don't think it would bother me anyway because I think I've lived long enough through misery. Nothing has been the way it should so it doesn't matter to me."

Subject 11

Female, age 30.

Divorced, has one child.

Has B.Sc. Has done post graduate work.

She is the eldest of three children. Her parents are living and healthy.

She has no formal religious affiliation and doesn't believe in after-life.

She was diagnosed as having a brain tumor a year and a half ago and had surgery. Whether or not it is malignant is unclear. She was initially told the prognosis was poor. She reports if the tumor comes back there is nothing that can be done, patients tend to remain well until they get very sick and the tumor can come back any time, or not at all.

Change Experience #1 - when she came to Canada from another country (at age 4).

Change Experience #2 - the 2½ year period that preceded her decision to leave her marriage and the process involved in making that decision.

Change Experience #3 - the intimate union with a man following a two year period in which she had established a satisfactory independent life.

Change Experience #4 - the frequent need she has to take time to reassess the meaning the possibility of dying has in relation to her life. She describes this as a "taxing process."

There are two dominant themes expressed by this subject who describes herself as a "process person": (a) her life has constituted a series of changes and has not proceeded in a "linear fashion," and (b) relying on her personal resources in accommodating to these changes has been an ongoing focus of her life.

All change experiences have been "private" for this subject and

out of each experience evolved change, always in the direction of personal growth (such as becoming emotionally stronger, more mature, independent, developing increased self-direction). Living with the possibility of becoming ill again is not traumatic for her. She maintains that the illness fits her personality and it is "O.K. to live with an open-ended diagnosis." She describes herself as a "survivor." To this subject, dying represents "the end." She expresses no fear of dying, maintaining that she lives with the possibility of dying day by day. However, she is adamant that she would not expose herself to the kind of dying process that is often dictated to cancer patients by the medical profession. She would choose to die her own way, the way she has lived her life.

Subject 12

Female, age 38.

Married, has two children.

Completed grade 12 and a two year business college program.

She is the youngest of two children. Her father died of cancer and her mother is still living.

She is a secretary.

She has no formal religious affiliation but describes herself as "very religious in my heart." This involves a personal belief in God. She believes in after-life. What she "wants to believe" is that there is a place where we go and have a life that is more valuable than the one we have here, more "towards perfection."

Chronic leukemia was diagnosed in 1976. She has been in remission

for two years and considers herself cured. She was told the leukemia was in the beginning stages and with therapy and the proper diet she would "pull through."

Change Experience #1 - when she was diagnosed as having cancer.

Change Experience #2 - when, in the early years of her marriage, she and her husband had financial problems (which was a new experience since she came from an affluent family).

Change Experience #3 - the upheaval she experienced during childhood because of her parents' problematic relationship. From 13 to 15 years old, prior to her parents' decision to separate, this was at its height.

Change Experience #4 - the culture shock she experienced upon coming to Canada from a European country.

All of the change experiences described by this subject are referred to as private and negative with the exception of change experience #4 (which didn't have the strong emotional impact associated with the other three). Feelings connected to them are anger, frustration, fear, feeling frantic. However, the changes evolving out of each experience are, in the subject's view, positive (i.e. a redefinition of values away from materialism, increased maturity, independence). She handled change practically and concretely in all situations (budgeting carefully in change experience #2, using her grandmother's home as a haven in change experience #3). In handling her illness she perceives herself as having "put up a fight" by maintaining her own balance as much as possible and also doing con-

crete things (such as reading about cancer and establishing her own diet). Feelings of anger and powerlessness were greater prior to the diagnosis when she was aware she was ill and was repeatedly told by doctors that nothing was wrong. There is fear associated with dying for this subject, primarily, she thinks, because she isn't ready for it. She believes she would not feel the same way if she was older.

Subject 13

Male, age 66.

Married, has eight living children (3 died).

Education equivalent to first year of university.

He has one half brother and five half sisters. His father died when he was 15 days old.

He is employed as a co-ordinator of an organization. He previously worked as an administrator of several organizations.

He is a Roman Catholic, very active in the religious community and believes in after-life.

He was originally diagnosed as having cancer of the thyroid in 1970 which was successfully treated by surgery. In 1978 he was diagnosed as having cancer of the lymph glands and is on chemotherapy. He doesn't know what the prognosis is.

Change Experience #1 - in 1957 when his 15 year old daughter became ill with cancer and subsequently died.

Change Experience #2 - when his last child, a son, choked to death at nine months of age.

Change Experience #3 - when he received the second diagnosis of cancer.

In this subject's view, all the change experiences described have had positive impact on him. For example, change experiences #1 and #2 presented the opportunity of bringing the family closer together. All experiences are also perceived as being tasks that were sent by God (along with the strength required to encounter them). The predominant feeling in dealing with change is acceptance. He states that "the feeling is always the same . . . the best way is to accept it . . . that's the way you can benefit most. If you accept it you can get some strength from it." Some expressed fear is associated with dying but, consistent with the positive attitude expressed repeatedly, he believes it is more important to think about living. His basic life orientation, expressed in his commitment to "community" and "life" is particularly strong at this point in time. In summary, a positive attitude, loosely framed in a religous structure, characterizes this subject's relationship to change.

Subject 14

Male, age 53.

Married, has three children.

Completed grade 12.

He is one of four children; one brother is still living. His mother is living, father died when he was a child.

He is employed as an office manager.

Nominally, he is a Roman Catholic but doesn't attend church. He believes in religion but likes to practice it "my way." He thinks there is a strong possibility that after-life exists.

He had his first stroke in 1972 and has had consistent health problems since then (i.e. two more strokes, a gall bladder operation, a heart attack). He describes himself as living on "borrowed time."

Change Experience #1 - when mother remarried when subject was 13.

Change Experience #2 - encounter with war in Korea (particularly the loss of life he witnessed "for no reason at all").

Change Experience #3 - when he was diagnosed as having an illness that would be progressive and that would severely restrict his activities.

The pattern in this subject's orientation toward change is a trend toward describing it in a positive way but, simultaneously, having negative feelings associated with it. While he has accommodated to change in an overtly accepting manner, on a more covert level the adjustment is not so smooth. Resentment is the consistent feeling associated with each change experience and these experiences are, generally, viewed by the subject as tending to make him "tougher." The manner in which he is coping with his illness is "doing the best I can day by day." In regard to the thought of dying he tries "to kick it out of my head." Yet, he frequently wonders if he will awaken in the morning. He expresses no fear of dying but makes it immediately clear that the doctors tell him that "subconsciously" he is fearful.

Subject 15 (Pilot Subject 2)

Female, age 58.

Single.

Has B.A. and diploma in Early Childhood Education.

She is one of six children.

She teaches kindergarten.

She is Roman Catholic (a nun). She believes in after-life.

In 1965 she was diagnosed as having lymphoma (which she described as cancer of the lymph system). She was told then she had from one to 15 years. She thinks the prognosis is good, states the doctors say she is supposed to die in 1980 but she doesn't think this will happen.

Change Experience #1 - when the initial diagnosis of cancer was made.

Change Experience #2 - when, at age 31, she was stationed in a small community that she liked and was given orders that she would have to move on three days notice.

Change Experience #3 - at age 12 she had a very close friend whose family left the community suddenly and secretly. The subject saw them off at the train station and never saw them again.

Change Experience #4 - when, at age 13, her six year old sister died suddenly.

Most of the change experiences in this subject's life are characterized by feelings of loneliness, rejection and/or abandonment and, sometimes, depression. The positive impact that other people made on her during these experiences is a consistent thread. For example, the doctor who told her she could "curl up and die" or fight her disease (in change experience #1), the nun who reached out to her (in change experience #2), being with her mother and peers (in change experience #4) all had significant influence on her resolution

of the experiences.

Positive results evolved out of each change experience for this subject in the form of increased thoughtfulness, increased flexibility in adapting to change, greater independence. In each instance the change experience is described as positive or as having both positive and negative components. Evolving out of the subject's religious orientation, each experience is viewed as having a purpose, as being "ordained by the Lord." Dying is not feared by her but peaceful, accepting feelings are associated with it. Yet, she does not currently view herself as being close to death and attributes this, in part, to yet another external source. ("I know I have the support of over 1200 sisters behind me . . . You feel the strength behind you").

Subject 16 (Pilot Subject 5)

Male, age 43.

Married, has been divorced, has two children.

Completed grade 12.

He is one of five children. His mother is living, father died of a heart attack.

He is employed in the communications industry.

He was baptized Roman Catholic but is not an active member of any religious community. He believes in God and in the "power sources within ourselves." He also thinks there is a religion based on "self-awareness or self-help." His belief in after-life has developed over the past few years.

He was diagnosed as having cancer of the lymph system in 1961 at

which point he was told he had one year to live. He has been treated with radiation and chemotherapy. He believes he has control over the disease and that a "program for survival is an excitement of life."

Change Experience #1 - the realization that he had to be outdoors (as a survival technique) and in contact with a particular style of nature (birds of flight).

Change Experience #2 - has two parts, (a) the period of pride during his illness in which he felt God had not helped him and he would do it his way, and (b) a softening toward others.

Change Experience #3 - the birth of his first son.

Change Experience #4 - when he regarded himself as terminally ill and dying.

The need to survive is the primary theme in this subject's functioning. All the change experiences (with the exception of #3) are related to his illness and his determination to "survive" at all costs. In this arena he regards himself as a "warrior" who has succeeded in not giving in to his cancer and as exceptional in this regard. In contacts with colleagues and other cancer patients, he views himself as a teacher and mentor. ("For each person in crisis someone has the magic words. More often than not, I am that person.")

His personal brand of self-awareness out of which he developed what he refers to as "survival techniques" has been the dominant feature of his life since the initial diagnosis was made 18 years ago. This need is so significant to him that he believes if he stopped fighting he would die. At those times that he is tired, for example, he chooses somebody to take over the "battle" for him. The "survival

techniques" have a strong self-focused quality and have changed his life style in a manner that he indicates has paid a heavy toll in his relationship system. Change experience #3 (the birth of his son) stands out in that it is not illness related. However, there is indication that he viewed it as highly personal, self-related experience in which he had "replaced" himself by law.

Subject 17

Male, age 50.

He has been divorced twice, has four living children.

Completed grade 12.

He is the youngest of four children.

He is a farmer and musician.

He was brought up in the Protestant faith but, currently, is not affiliated with any church. He does not have a firm conviction about after-life.

He had cancer of the thyroid in 1975 which was treated surgically. He doesn't have any form of cancer now and regards himself as cured.

Change Experience #1 - when his 14 year old son died suddenly in 1971.

Change Experience #2 - the break up of his first marriage.

Change Experience #3 - the death of his father.

Change Experience #4 - the second marital break-up.

Change Experience #5 - when he was diagnosed as having cancer.

This subject experienced considerable ongoing stress in his life. In a 15 year period he had two marriage break-ups, experienced the death of three people to whom he was very close, was fired from his

job, had legal battles with his family and had cancer.

The primary theme, up to the subject's diagnosis of cancer, was of a person who took no control over his life, left most change experiences unresolved (1 and 2, for example) and handled each situation in a private, introverted manner. In his words, "I wasn't master of my destiny in any way. I felt completely trapped . . . I really was a vegetable." The cancer represented a turning point in his life at which time contemplating the thought of dying resulted in his deciding that his life, as it was then, wasn't worth living. He ultimately made some concrete changes in his life (which included leaving his second marriage). He does not now think of dying (while, previously, he considered himself to be suicidal). He expects that he will live another 50 years since he has another lease on life and maintains: "I've adopted quite a different life style" and describes himself as feeling free and liberated.

Subject 18

Male, age 42.

Married, has two children.

Has B.A.

He is one of four children, his parents are both dead.

He is president of a variety of companies.

He is Roman Catholic and very active in the religious community. In regards to a belief in after-life he states "there better be something." He describes his struggle with this question as a crisis he is currently experiencing.

He was diagnosed as having cancer of the lymph nodes in 1976 at

which time he was given two to three years to live. He is currently in remission. He states he was originally told there was a 5% chance he would still be alive in 10 years and he told the doctors he would "still be around" then.

Change Experience #1 - when he failed grade 3 and his parents placed him in a "Dickensonian" boarding school (where he remained for 3½ years).

Change Experience #2 - when, for 10 years, he was heavily invested in his father's business, working 90 hours a week. He views this as a highly stressful but personally satisfying time.

Change Experience #3 - in 1970 he started a new company. Six years later, one of his partners left, leaving the company in heavy dept.

Change Experience #4 - when he first learned he had cancer (which occurred almost concurrently with the business difficulty described in change experience #3).

The pattern exhibited by this subject is a high energy involvement in each change experience he described. Despite the fact that all experiences had very stressful and sometimes negative components, he succeeded in extracting something positive from each (for example, the academic success in change experience #1 and putting the business back on its feet in change experience #3). The most outstanding feature in this subject's confrontation of dying is the dramatic change in life style (from a strong business-oriented, materialistic orientation to a more interpersonal, humanistic stance). In fact, he describes the anniversary of his diagnosis as being "four

years since I've been alive." Facing dying, is described, as well, as producing feelings of elation and exhilaration and as a "real challenge." To him it has a strong, underlying personal purpose embedded in the belief that his suffering will help other people. Evolving out of this belief is his statement that he would want to die slowly if he had the choice. Despite the fact that a change in life style has emerged, this subject is basically approaching illness and dying in the same general manner that he has approached other times of change--with energy, enthusiasm, positivism and drive.

Subject 19

Male, age 44.

He is divorced, has two children.

He completed grade 12.

He is the oldest of three children; two are still alive. His parents are both living.

He owns several companies and is a professional musician and photographer.

He is of Greek Orthodox religion but doesn't attend church. He states he has a personal religious connection but doesn't "display it openly." He believes in after-life which will take the form of a "mundane existence with no highs and no lows."

He was diagnosed as having cancer of the lymph system in 1974. Initially, he was given a 90 day survival period without treatment. He received chemotherapy during the first year and considers his illness to be arrested. He believes his life span has been shortened by the disease and thinks he will live into his late 50's. He

states his illness has not hindered anything in his life; in fact, the reverse is true. He describes himself as being "delighted to be alive."

Change Experience #1 - the period (of 5 years duration) leading up to his divorce. He feels the stress evolving from this situation played a major role in the etiology of his cancer.

Change Experience #2 - when a woman, with whom he had established a relationship following his divorce, announced her engagement to another man with no warning.

Change Experience #3 - when he was first married he worked for the U.S. Air Force in another city. He left to return to Edmonton to "start all over again" and was under financial stress.

Change Experience #4 - when he was told he had cancer and would likely die within 90 days without treatment.

All the change experiences in this subject's life have a relationship component attached to them, either directly or indirectly. For example, a key to his adjustment to change experience #3 was the extended family atmosphere with his colleagues (in which he describes himself as joining the main stream and following the line). Change experience #4 brought him the "right woman" in that his relationship to her was solidified as she supported him through his illness. Feelings associated with change are both negative and positive and the manner in which he coped with it was very activity oriented. Personal changes that were positive resulted from all change experiences, particularly as he views them in retrospect. The cancer is unequivocally viewed by this subject in a positive manner. He describes it as positive "all the way" and believes he is now living

his life more fully as a result of being ill. Most important to him at this point in time are his children, music, business and "progress" in general. He expresses no fear of dying but, consistent with the fact that he is a "doer," he has a concern that he will die leaving things undone. Finishing what he has started is very important to him.

Subject 20

Male, age 37.

Married, has two children.

Fellow of Royal College of Surgeons.

He is an only child. His parents are still living.

He is a Roman Catholic but doesn't have a strong religious orientation. He is inactive in the religious community. He believes in after-life in the form of a "peaceful type of thing rather than any form of humanity."

He was diagnosed as having a malignant tumor in 1976. It was treated by surgery. There was a four day period between operations before he knew how far the cancer had spread. He now considers himself cured.

Change Experience #1 - when, after medical school, he joined the Armed Forces and was stationed in Europe.

Change Experience #2 - the period of adjustment that was required for the six months following his marriage.

Change Experience #3 - when, at high school age, he was sent to boarding school (where he remained for three years) before he felt he

was ready for it.

Change Experience #4 - when he was mountain climbing and fell down a hanging glacier. His life was saved by jamming his boot (with a cramp-on) into a crack in the ice, thus breaking his fall.

Change Experience #5 - the four day period between his first and second operations when he recognized he could easily die from cancer.

This subject describes himself as a person who "has never been able to be that close to people." Change experiences 1 through 4 are all described as private and all have negative components (with the exception of #1 which is generally viewed by the subject as a happy time in his life). Change experience #5 stands out as having a different tone in that it is regarded as highly positive and public. Many people were closely involved in this experience and the positive aspect is defined by the subject as being related to recognition of his own helplessness and discovering that "other people are quite nice." However, it was a "one-shot" situation that did not carry over into relationships with people after the experience was over. He states that the thought of dying didn't frighten him then (or in change experience #4) but does frighten him now. He attributes this to the fact that he hasn't been "forced" to look at it for awhile.

Subject 21

Male, age 71.

Married, has seven living children and 30 grandchildren.

Completed grade 9.

He is one of 13 children. Both parents died of strokes.

He is a retired auto mechanic.

He is Roman Catholic. He is active in church activities, belongs to a charismatic group (bible study and healing). He believes in after-life, thinks he will be "revived again" but doesn't know what form it will take. He believes he will be in heaven someplace.

He was diagnosed as having leukemia six years ago. He has been treated by ongoing oral medication and thinks it has really helped. He feels healthy and believes that the disease is under control.

Change Experience #1 - the financial hardship he experienced during "the dirty 30's."

Change Experience #2 - the death of his first child.

Change Experience #3 - the physical weakness and loss of energy associated with having leukemia.

"If it has to be it has to be . . . That's the way I take life" summarizes the philosophy behind this subject's responses to change. This reaction evolves out of a strong religious framework in which all personal events are perceived as having been sent by God. Each change experience is basically viewed as a private matter and accepted as a situation to be confronted and dealt with in the best way possible. Pride in coping successfully with hardship (change experience #'s 1 and 2) is a dominant theme. Having leukemia did not create any anxiety for this subject. The major difficulty evolved around the temporary need to lead a less active life and to deal with being physically tired and without energy, states that were foreign to him. He sees dying as completely in God's hands and states he has

"no feeling whatsoever about it . . . If it happens today it happens, if it happens tomorrow, it happens and I can't do nothing about it."

Demographic Information

Table 1

Age of Respondents

Age Range	Males[a]	Females[a]
30-39	1 (4.8)	2 (9.5)
40-49	5 (23.8)	1 (4.8)
50-59	2 (9.5)	2 (9.5)
60-69	1 (4.8)	5 (23.8)
70+	1 (4.8)	1 (4.8)

[a]Numbers in parentheses indicate percentage.

Table 2

Marital Status of Respondents

Marital Status	Males[a]	Females[a]	Total[a]
Married	8 (38.1)	5 (23.8)	14 (61.9)
Divorced	2 (9.5)	2 (9.5)	4 (19.0)
Widowed	0 (0)	2 (9.5)	2 (9.5)
Single	0 (0)	2 (9.5)	2 (9.5)

[a]Numbers in parentheses indicate percentage.

Table 3

Educational Level of Respondents

Education Completed	Males[a]	Females[a]
Grade 8	0 (0)	2 (9.5)
Grade 9	1 (4.8)	1 (4.8)
Grade 12	6 (28.5)	3 (14.3)
Some university training	1 (4.8)	2 (9.5)
Formal education beyond university degree	2 (9.5)	3 (14.3)

[a]Numbers in parentheses indicate percentage.

This population of 10 male and 11 female subjects ranged in age from 30 to over 70 years, with the majority (57.2%) being in the 40-49 and 60-69 year old age brackets (Table 1). The largest percentage (61.9%) was married (Table 2) and 42.8% completed grade 12 (Table 3). The subjects varied considerably in religious affiliation. Some, for example, had fundamentalist views while others maintained they had no religious belief system. The largest religious group (38%) was Roman Catholic. Sixty-two percent of the population described themselves as inactive in the religious community; however, 71.4% expressed a belief in after-life (Table 4).

Analysis of the subjects' health status reveals that with the exception of three subjects, all were or had been cancer patients. One subject experienced several strokes and heart attacks while another came close to dying when she was hospitalized for pneumonia. A third,

Table 4

Religious Affiliation as Described by Respondents

	Sex		Participation in Religious Community		Belief in After-Life			
	Male	Female	Active	Inactive	Yes	No	Uncertain	Total[a]
Self Described Christian	0	2	2	0	2	0	0	2 (9.5)
Roman Catholic	5	3	5	3	7	0	1	8 (38.0)
United Church	1	0	0	1	0	0	1	1 (4.8)
Moral Re-Armament	0	1	1	0	1	0	0	1 (4.8)
Ukrainian Orthodox	0	1	0	1	1	0	0	1 (4.8)
Greek Orthodox	1	0	0	1	1	0	0	1 (4.8)
Protestant (Denomination Unspecified)	1	1	0	2	0	0	2	2 (9.5)
Personal Belief System	1	2	0	3	3	0	0	3 (14.3)
None	1	1	0	2	0	2	0	2 (9.5)
Total[a]	10	11	8 (38)	13 (62)	15 (71.4)	2 (9.5)	4 (19)	21 (100)

[a]Numbers in parentheses indicate percentage.

who had received surgery for a brain tumor, did not receive a definitive cancer diagnosis. Of the 18 cancer patients, nine were receiving ongoing medical treatment and nine were not. For the most part, the health of the latter group was monitored by periodic physical examinations. Two subjects (1 and 2) were in the final stage of illness and in a weakened condition when interviewed.

Change Experiences: Description, Characteristics and Outcome

Description

Eighty-eight change experiences were identified by the 21 subjects. Four categories of change experience (those related to relationships, illness, death and geographical moves) accounted for 80.7% of the total (Table 5). Those that were relationship and illness related were predominant, and constituted 49.99% of the total. The remaining four categories of change experiences, those that revolved around work, finances, religion and miscellaneous situations, represented the balance (19.31%). No differences were found in the nature of change experiences described by male and female subjects.

The majority of change experiences categorized as relationship-oriented evolved out of marital discord, separation and/or divorce, or the termination of a significant male-female relationship. In only one case was a positive, intimate union with a person of the opposite sex identified as an experience of change. A small number of such experiences were defined as being related to childhood and adolescent relationships. In all the illness-related change experiences (with the exception of one), the illness identified was that of the subject.

Table 5

How Respondents Defined Change Experiences

Change Experiences Related to	Male[a]	Female[a]	Total[a]
Relationships	11 (12.50)	12 (13.63)	23 (26.13)
Illness	11 (12.50)	10 (11.36)	21 (23.86)
Death	6 (6.82)	8 (9.10)	14 (15.92)
Geographical Moves	4 (4.55)	9 (10.23)	13 (14.78)
Work	2 (2.27)	3 (3.41)	5 (5.68)
Finances	3 (3.41)	2 (2.27)	5 (5.68)
Religion	1 (1.14)	2 (2.27)	3 (3.41)
Miscellaneous	2 (2.27)	2 (2.27)	4 (4.54)

[a]Numbers in parentheses indicate percentage.

In addition, the time when the diagnosis was made was most frequently defined as having the strongest emotional impact (as opposed to the ongoing reaction to the illness). Death-related experiences of change exclusively concerned the death of a close relative (i.e. son, daughter, husband, grandfather, sister).

Characteristics

Change experiences were generally described by subjects as positive as often as they were defined as negative. However, similar experiences were sometimes viewed by subjects in dissimilar ways. For example, the death of a son was described by subject 7 as a traumatic, negative experience while subject 13 regarded his daughter's death positively in that it brought the family closer together. Similarly, subject 10 found adjustment to married life difficult and lonely and

resented the "hard work" involved. Subject 6 also defined the early years of marriage as times of financial hardship and hard work. Yet, she referred to them as "good times" in which the realities of her life were taken for granted.

Frequently, single change experiences were defined by the same subject as having both positive and negative components, particularly if they were resolved in an acceptable way. On one level, subject 15 had a negative association with the depression and feelings of rejection that evolved from her cancer diagnosis. Simultaneously, she viewed this event as positive because "I was mad enough to say I am going to fight this myself and you'll never see me 'down' again." Subject 18 also described his placement in a boarding school at age eight as having both positive and negative impact, negative in the sense that he felt abandoned and positive because he developed renewed academic faith in himself as well as a "strong backbone."

In addition to the emotional tone of change experiences, another dimension of their character was represented by the time involved in their resolution. Some such experiences were clearly time-limited. This category included dealing with the effects of an initial diagnosis (subjects 3, 4, 12, 15), affiliation with a specific religious structure (subjects 1 and 4) and geographical moves (subjects 2, 3, 12, 15). However, a significant number of change experiences did not have clear-cut time constraints and were more process oriented. Some continued over a period of years. Subject 9, for example, identified the prolonged resentment associated with her widowed mother living with her as such an experience, while subjects 11, 17, and 19 all

placed the extended periods leading up to their marital separations (as opposed to the separation per se) in the framework of experiences of change. The view of change as process is epitomized in the outlook of subject 11 who referred to her life philosophy as a "process philosophy" and regarded specific acts of change (such as marital separation) as anti-climactic to the processes that preceded them,

Outcome

What was the impact of change experiences? Were they isolated experiences that, once completed, were set aside, or did they have a more pervasive effect on subjects' lives? A limited number of change experiences were regarded as not having any long range influence (i.e. subject 7 perceived herself as being "too molded in the groove" to change). However, the majority of subjects indicated that a shift or change emerged from such experiences. Although negative changes were identified (decreased trust of others, increased irritability, for example), positive changes, resulting from both negative and positive change experiences were often described. The nature of such changes related to (a) dramatic shifts in life style, (b) clarification and/or change in values (becoming less materialistic, establishing a different set of life priorities, developing a clearer personal sense of life), and (c) interpersonal changes (developing confidence, maturity, independence, becoming less self-centered, "growing up").

For several subjects, confrontation of negative experiences of change clearly increased their self-reliance and made the prospect of continued change less threatening. Subject 5 attributed her increased adaptability to change to a sudden geographical move that

occurred earlier in her life, while subject 21 indicated that living through the "dirty 30's" gave him the assurance that he could cope successfully with another national depression. Similarly, having experienced the death of a child, if the death of someone close occurred again he would "know exactly what to do." This trend was clearly reinforced by subject 6 who concluded that a stressful financial period "made a better person out of me . . . . We didn't have anything . . . . Still, we survived. That's what we did! We survived!"

Styles of Coping with Change

The Practical Approach to Change

Dealing with change in a concrete, practical fashion was the dominant mode of functioning for a circumscribed group of subjects. These people were activity-oriented in their relationships to change, downplayed (or denied) emotional reactions to the change situation and, in comparison to other subjects, had a higher level of engagement in specific decision making behaviors. This trend was observed clearly in subjects 3, 11, 18, and 19 and less consistently (i.e. in relation to some, but not all, of the identified change experiences) in subjects 6, 8 and 12. Of the former group, three were men and one was a professional woman who described herself as having a high proportion of "male values."

Additional information about this particular response pattern can be obtained from an overview of one subject's response to change. Subject 3 identified three change experiences, (a) his move to Edmonton (and the subsequent termination of a relationship that was associated with that move), (b) the emotional upheaval and work pressure he ex-

perienced at age 40, and (c) the diagnosis of cancer. Concrete action, explicitly identified by the subject, was taken to deal with each situation. He attributed the successful resolution of the first experience, for example, to the fact that he was able to "diversify," develop his interests, meet new people, engage in expanded activities and, thus, viewed himself as "successful." The second change event was accompanied by high blood pressure, had a stronger emotional component, created more personal upheaval and was not so promptly worked through. It was ultimately handled as the subject deliberately redefined lines of job responsibility and used available external resources to reduce specific life pressures. Compared to this experience, the cancer diagnosis had less dramatic effects and was not defined, generally, as being emotionally stressful. ("Since I've been diagnosed and know that I have cancer . . . that's something concrete to really zero in on and donate all my attention to, I don't have high blood pressure any more.") The subject responded to the diagnosis by taking care of the material, financial and medical aspects of his life to "make sure that if and when I go that I've done everything physically and mentally possible to make sure that the family was taken care of." Consistent with the above pattern, a practical note has also dominated his attitude toward his cancer, in that attempts have been consistently made to maintain the "proper frame of mind" as a mode of overcoming his illness.

Outer-Directed vs. Inner-Directed Persons: Coping with Change

Analyses of the interview data and the responses of 17 subjects on the LS/DSQ described another pattern that identified some subjects as inner-directed (congealing) and others as outer-directed (eruptive)

in their approach to change. In this discussion the term inner-directed is regarded as synonymous with congealing while outer-directed is treated as synonymous with eruptive.

The LS/DSQ was analyzed by determining the percentage of eruptive and congealing responses given by each subject in relation to change experiences (a) other than those that were related to life-threatening illness and/or dying, and (b) that were associated with life-threatening illness or dying (Table 6). The numbers of eruptive and congealing responses were calculated after mid-point values were discarded and were then converted to percentages. For example, subject 10 gave a total of 19 eruptive responses and 31 congealing responses, indicating there were no mid-point responses. Subject 18 gave 31 eruptive responses and 15 congealing responses, indicating that four responses fell at mid-point.

The percentage difference between the total of eruptive and congealing responses for each subject was determined (Table 7). The total number of eruptive responses was calculated by adding the number of eruptive responses of non-dying change experiences to those of dying change experiences. The total number of congealing responses was calculated in the same way. Mid-point responses were again discarded and the totals converted to percentages. Those subjects whose percentage difference was 12% or less were labelled mixed (subjects 6, 12, 13, 21). On the basis of the direction of their responses, the remaining subjects were categorized as eruptive (subjects 11, 14, 18, 19) or congealing (subjects 2, 3, 5, 7, 8, 9, 10, 17, 20). The mean percentage difference for each group was--mixed (8.5), eruptive (32.25),

Table 6

Eruptive and Congealing Responses on the LS/DSQ

	Eruptive Responses		Congealing Responses	
Subject #	Living[a]	Dying[a]	Living[a]	Dying[a]
* 2	10 (42)	7 (29)	14 (58)	17 (71)
3	6 (40)	6 (46)	9 (60)	7 (54)
5	5 (21)	4 (20)	19 (79)	16 (80)
* 6	11 (52)	10 (42)	10 (48)	14 (58)
* 7	7 (37)	10 (45)	12 (63)	12 (55)
* 8	7 (35)	5 (26)	13 (65)	14 (74)
9	9 (43)	4 (18)	12 (57)	18 (82)
10	10 (40)	9 (36)	15 (60)	16 (64)
11	15 (62.5)	17 (71)	9 (37.5)	7 (29)
12	11 (55)	11 (55)	9 (45)	9 (45)
*13	13 (68)	6 (37.5)	6 (32)	10 (62.5)
14	12 (52)	15 (65)	11 (48)	8 (35)
17	5 (22)	4 (18)	18 (78)	18 (82)
18	14 (64)	17 (71)	8 (36)	7 (29)
19	18 (78)	15 (65)	5 (22)	8 (35)
20	11 (55)	2 (8)	9 (45)	23 (92)
*21	11 (50)	8 (38)	11 (50)	13 (62)

*Subjects over 60 years old.

[a]Numbers in parentheses indicate percentage (calculated by excluding neutral responses).

Table 7

Percentage and Percentage Difference of Total Eruptive and Congealing Responses on the LS/DSQ

Subject Number	Eruptive	Congealing	Difference between Eruptive and Congealing	Category
2	35.4	64.6	29.2	Congealing
3	43	57	14	Congealing
5	20.5	79.5	59	Congealing
6	47	53	6	Mixed
7	41	59	18	Congealing
8	30.8	69.2	38.4	Congealing
9	30.2	69.8	39.6	Congealing
10	38	62	24	Congealing
11	67	33	34	Eruptive
12	55	45	10	Mixed
13	54	46	8	Mixed
14	58.7	41.3	17.4	Eruptive
17	20	80	60	Congealing
18	67.4	32.6	34.8	Eruptive
19	71.7	28.3	43.4	Eruptive
20	29	71	42	Congealing
21	44	56	12	Mixed

and congealing (35.4).

Using these tentative categories, the interview tapes were examined to see what differences might exist. In some areas, no differences were observed between eruptive, congealing and mixed subjects. Each group described a variety of change experiences; no particular pattern was associated with any group. Differences were not evident in level of religious involvement between the eruptive and congealing subjects (75% of the eruptive subjects and 78% of the congealing described themselves as inactive in a religious community). However, the mixed group was different in this regard; half indicated they were active in a religious community and half reported they were not. Some differences were also described in belief in after-life. Seventy-five percent of the eruptive group and 56% of the congealing group described a definite belief in after-life but 33% of the latter group reported uncertainty about what was believed. All of the subjects in the mixed group stated they believed in after-life. In other areas, the differences between these groups were more distinct.

The eruptors. This group of one female and three male subjects ranged in age from 30 to 53 years and had a mean age of 42.25 years.

The interview data indicated that these people were highly inclined to view change experiences in a positive light or to define single change events as both positive and negative. Associated with this trend was a positive, present and future-oriented life attitude in which few regrets about past situations or behaviors were expressed.

For subject 14, all experiences of change were positive, including his current illness. He regarded himself as "lucky" to have survived heart attacks and strokes. In a similar vein, he maintained he has had "a real good life" and would not choose to change it in any way. Subject 19 would have chosen to change only one part of his life (related to his marriage). He characterized himself as a person who operated on "gut feelings, instinct" and never looked back. At the time of the interview present and future were important to him--his children, his music, the growth of his company and "progress in general." The theme of having good fortune was also expressed by subject 11 who stated "When I talk to people about my illness or what life has been like over these last years, it's always an overriding impression that's left with me that, yeah, things have been kind of tough sometimes but, gee, I've been lucky."

On a more subjective level, these subjects gave the consistent impression of being verbal, energetic people who maintained a high level of involvement in their respective experiences of change. In response to change, other people played a significant role (for friendship, support, social interaction, intimate connections, and as colleagues). However, these relationships were devoid of dependency. Under pressure, these subjects were inclined to work situations out alone, a mode that subject 14 used in resolving the second change experience as "we were brought up that way." The relationship between self and others was further identified by subject 11 who maintained she "put it together within myself . . . before I share it with others."

Individual items on the LS/DSQ were analyzed to obtain additional information on subjects' self-perceptions. This was accomplished by regarding responses one through three as representative of one end of the pole and responses five through seven representative of the other. Mid-range responses were omitted. The responses of the eruptors were calculated independently from those of the congealers and the mixed group. For example, congealers described themselves as victims 12 times and as participants three times on the Victim/Participant item on the LS/DSQ (Table 9). These numbers were then converted to percentages.

Self-perceptions of these subjects were, for the most part, supportive of the trends outlined above. On the LS/DSQ they described their behavior in response to change situations as participating (Table 9), open (Table 10), active (Table 11), moving toward others (Table 12), independent (Table 13) and as coping with change in a manner that was both public and private.

The congealers. This group of four male and five female subjects ranged in age from 37 to 71 years and had a mean age of 53.7 years. The female subjects, with a mean age of 61.6 years, were older than the males whose mean age was 43.8 years.

An analysis of these subjects' views of change indicated that they identified a high proportion of experiences of change as negative. Feelings of anger, sadness, loneliness, hopelessness, resentment, depression were often associated with them. In comparison to the eruptors, they tended to have more regrets about the way these

Table 8

Public/Private Responses on the LS/DSQ

	Public[a]	Private[a]
Congealers	4 (24)	13 (76)
Eruptors	4 (57)	3 (43)
Mixed	1 (17)	5 (83)

[a]Numbers in parentheses indicate percentage.

Table 9

Victim/Participant Responses on the LS/DSQ

	Victim[a]	Participant[a]
Congealers	12 (80)	3 (20)
Eruptors	1 (13)	7 (87)
Mixed	2 (29)	5 (71)

[a]Numbers in parentheses indicate percentage.

Table 10

Closed/Open Responses on the LS/DSQ

	Closed[a]	Open[a]
Congealers	10 (63)	6 (37)
Eruptors	1 (13)	7 (87)
Mixed	2 (33)	4 (67)

[a]Numbers in parentheses indicate percentage.

Table 11

Passive/Active Responses on the LS/DSQ

	Passive[a]	Active[a]
Congealers	11 (73)	4 (27)
Eruptors	0 (0)	8 (100)
Mixed	0 (0)	8 (100)

[a]Numbers in parentheses indicate percentage.

Table 12

Withdrawing into Self/Moving Toward Others Responses on the LS/DSQ

	Withdrawing into Self[a]	Moving toward Others[a]
Congealers	13 (81)	3 (19)
Eruptors	2 (25)	6 (75)
Mixed	3 (43)	4 (57)

[a]Numbers in parentheses indicate percentage.

Table 13

Dependent/Independent Responses on the LS/DSQ

	Dependent[a]	Independent[a]
Congealers	6 (33)	12 (67)
Eruptors	0 (0)	8 (100)
Mixed	1 (17)	5 (83)

[a]Numbers in parentheses indicate percentage.

events were handled and frequently stated they would do things differently if they were presented with an opportunity to re-live the experience. For example, referring to the years she reluctantly cared for her aging mother, subject 9 maintained "I think I was a very foolish woman . . . I was kind of wishy-washy. I'd be a lot more positive about what I wanted and didn't want and I just wouldn't let people walk on me."

A passive involvement characterized the congealers' responses to change. In this context, motivation for specific behaviors frequently evolved from environmental cues and/or societal role expectations. Subjects frequently took the paths of least resistance. Subject 2 spent a period (as a new mother) living for alternate one week periods with her parents and in-laws. Although she referred to the situation as "traumatic," she indicated it was a "natural thing to please them both." Subject 10, who described marital friction, maintained that she gave in to it and accepted that "I've got to do what he says," while subject 17 indicated that (in relation to change experience #4), "I wasn't master of my destiny in any way. I felt completely trapped . . . I really was a vegetable." Positive action was therefore, seldom taken by these subjects on their own behalf. Subject 7 "stuck it out" for six years living in a teacherage that offered nothing positive to her. When more concrete action was taken in dealing with change, an extended period of indecision usually preceded it. Subject 17, for instance, spent two periods of 14 years each in unhappy marriages before he decided to leave.

Reactions to change, as indicated, were not action-oriented for these subjects and, other than the immersion in hard work described by several (subjects 7, 8, 9, 17), change resolution did not take concrete forms. Although negative feelings were commonly experienced, they were not expressed to others. Under stress, withdrawal became more apparent and subjects described themselves as tense, worried, depressed and as crying.

These subjects' perceptions of how they handled change were generally different from those of the eruptors. They described themsevles as private (Table 8), as victims (Table 9), as withdrawing into self (Table 12), as being more closed (63%) than open (Table 10), and as more passive (73%) than active (Table 11). On the dependence/independence dimension, they were more similar to the eruptors (who all viewed themselves as independent). As Table 13 indicates, congealers also regard themselves as more independent (67%) than dependent.

The mixed group. This group of two male and two female subjects ranged in age from 38 to 71 years, and had a mean age of 59 years.

The interview data suggested that these people had characteristics in common with both the congealers and eruptors but, generally, were more similar to the latter group. For example, they identified experiences of change as negative (as did the congealers) and positive or as having both positive and negative components (like the eruptors). However, their response to change closely resembled that of the eruptors in that positive changes were most often defined as evolving from ex-

periences of change. The subjects in the mixed group were also action and solution-oriented in response to individual change events and closely resembled the eruptors in this regard.

Self-perceptions, as described on the LS/DSQ, supported the above results. Of the six items analyzed in Tables eight through 13, the only one on which the mixed subjects were similar to the congealers was in their view of themselves as more private (83%) than public (17%). On other items they described themselves in a manner that was akin to that of the eruptors--i.e. participants, open, active and independent.

The above analysis was based on the 17 subjects who completed the LS/DSQ. The interview impressions were consistent with the LS/DSQ results for all but one subject. This investigator would have classified subject 3 (who was categorized as congealing on the basis of the LS/DSQ) as eruptive because of his concrete, deliberate, practical approach to change. This may have resulted from a discrepancy between the investigator's evaluation and the subject's self-perception or from the fact that only 56% of his responses on the LS/DSQ could be scored as either eruptive or congealing. The remaining 44% fell in the mid-range.

Styles of Coping with Life-Threatening Illness

In the foregoing material, general response patterns to change were examined. The following sections explore (a) whether life-threatening illnesses were regarded by subjects as experiences of change, (b) what ongoing effects, if any, life threatening illnesses had on subjects' lives, and (c) how subjects responded to the prospect of dying.

Response to Life-Threatening Illnesses and the Threat of Dying

Different responses were given in relation to (a) life-threatening illnesses, and (b) consideration of the possibility of dying. Eighty-six percent of the population identified the period of initial diagnosis as a change event (Table 14). Most frequently, this was described negatively (because of physical discomforts, the required adaptation to physical changes and medical treatments, and the impact of being confronted with the diagnostic reality). In comparison, those subjects

Table 14

Respondents' Perception of Life-Threatening Illness as a Change Experience

	Males[a]	Females[a]	Total[a]
Yes	9 (43)	9 (43)	18 (86)
No	1 (5)	2 (9)	3 (14)

[a]Numbers in parentheses indicate percentage.

Table 15

Respondents' Expressed Fear of Dying

	Males[a]	Females[a]	Total[a]
Yes	4 (19)	1 (5)	5 (24)
No	5 (24)	10 (47)	15 (71)
Uncertain	1 (5)	0 (0)	1 (5)

[a]Numbers in parentheses indicate percentage.

who identified dying itself as a potentially fearful experience were few. Twenty-four percent of the subjects expressed a definite fear of dying.

Some subjects coped with the fear of dying by trying to avoid thoughts about it. Subject 13 maintained it was more important for him to think about living. Although subject 14 did not express overt fear of dying, he attempted to "kick" such ideation "out of my head." At age 38, subject 12 was afraid of dying, and stated she would "put up a fight" against dying at this stage in her life.

Some, but not all religious belief systems were found to reduce the fear of dying. Fundamental religious beliefs clearly served the purpose of defining attitudes toward dying, as well as living, for a number of subjects. The strong thread of continuity in the life of subject 1, for example, was her Christian belief. Dying was not regarded as a stressful or fearful event. It was accepted as God's will, along with the assumption that "there is a place prepared for me" in heaven. For this subject, dying was also regarded positively since she anticipated a reunion with her father (who died when she was eight months old). Similarly, subject 2 (a member of Moral Rearmament), handled her illness within the framework of her religious outlook, and stated she realized that "God is there and that's all that matters. Everything is in His hands." Consequently, she looked forward to dying as a "great adventure."

Being confronted with the possibility of dying did not have a strong negative impact on another group of subjects, those who had

experienced a great deal of trauma in their lives. To subject 7, who identified four negative change experiences (including the deaths of her husband and son), having cancer did not carry the same emotional impact as these experiences nor did the prospect of dying. She maintained she didn't mind dying "one little bit." Subject 10, who also defined changes in her life in consistently negative terms, referred to dying in the following way: "The way I look at it, if I went tomorrow I don't think it would bother me anyway because I think I've lived long enough through misery. Nothing has been the way it should be so it doesn't matter to me."

One subject (6) did not fear dying for a different reason. She recently had come close to dying in hospital. She associated contented, peaceful feelings with this experience and consequently felt unafraid and "ready to die."

Life-Threatening Illness as a Catalyst for a Life Style Change

For three subjects, having cancer precipitated a change in life style. Subject 16 had lived with the reality of his illnesses for 18 years and described three (out of four) illness-related change events. The theme of survival was particularly strong in his change experiences. What he referred to as "the basic instinct of self-survival" permeated his behavior since the diagnosis was made; in his opinion he adopted a life style that was solution-oriented. He credited himself with the fact that he was still alive and described himself as a "warrior" who relentlessly continued his battle for survival. This process, he stated, was lonely and had high costs

(i.e. the dissolution of a marriage). As well, his personal form of religion was based on "self-awareness or self-help" and he believed "the program for survival is an excitement of life."

The life style changes of subjects 17 and 18 evolved from a different source. Both were immersed in unsatisfying life situations prior to the onset of their illnesses (in one instance an unhappy marriage, and in the other, an over involvement in the world of work). Being faced with the possibility of dying represented a turning point for subject 17 who ultimately left his marriage. He proclaimed that having "beaten this cancer thing" he decided he should do something with his life. He reported he was now healthier and happier. "The first 50 years have been messed up and unhappy and the second fifty are going to be a lot different . . . I've adopted quite a different life style . . . . I just live entirely differently now."

To subject 18, the cancer diagnosis came as a "relief" (as if it provided the rationale for a change). He became more people-oriented, more interested in art and photography, and very fascinated about the dying process itself. He maintained "as of that point I changed my whole life style. I didn't let the business run me. I decided to run it."

Relationship between Patterns of Coping with Life Change Experiences and Life-Threatening Illnesses: An Overview

The information presented in the foregoing sections suggests there is a tendency toward consistency in the manner in which subjects coped with change in their lives and handled illnesses that were life-

threatening. In general terms, people who had a passive orientation tended to remain passive, those who engaged actively in change events continued to do so, and a strong religious framework dominated subjects reactions to all change events, whether or not they had a life-threatening component.

However, this trend did not hold true for all subjects in all situations. There were some outstanding exceptions. Subject 20 described himself as a person who wasn't able to be close to people. He described all change experiences, except the one associated with having cancer, as private. In the cancer related experience many people were closely involved and it was described as "positive" and "public." However, it was also regarded as a "one shot" experience that did not affect this subject's relationships to people in any permanent fashion. Although some subjects changed their life style as a result of their illnesses, there was no consistent indication that the overall mode of functioning was modified to any great extent. Subject 18, for example, continued to maintain the same high energy involvement in approaching the possibility of dying that had characterized his work orientation.

Did subjects perceive themselves as handling life-threatening illness and other change events consistently? The degree to which subjects responded consistently on Parts A and B of the LS/DSQ was examined item by item and the percentages of agreement were calculated. On the scale of seven, any given response was considered to be in agreement if the number circled on Part A was the same or one digit

away from that circled on Part B (Table 16). The results indicated that subjects had a reasonably high level of agreement. Agreement responses ranged from 48 to 100 percent for the 17 subjects to whom the LS/DSQ was administered. The overall mean was 66.53, and the means for females, males, and subjects over 60 years of age were similar.

Table 16

Agreement Responses on the LS/DSQ

Subject #	Sex	Agreement Responses	Disagreement Responses	Agreement %
* 2	F	16	8	67
3	M	25	0	100
5	M	22	3	88
* 6	F	14	11	56
* 7	F	15	10	60
* 8	F	15	10	60
9	F	17	8	68
10	F	14	11	56
11	F	21	4	84
12	F	15	10	60
* 13	M	18	7	72
14	M	18	7	72
17	M	15	10	60
18	M	13	12	52
19	M	14	11	56
20	M	12	13	48
* 21	M	18	7	72

*Indicates subjects over 60.

Means

Over-all mean-----66.53% (N=17) Male mean----------68.89% (N=9)

Female mean-------63.88% (N= 8) Mean for Ss over 60-----64.50% (N=6)

CHAPTER V

DISCUSSION AND IMPLICATIONS

The major objective of this investigation was to determine whether individuals respond to change in their lives in a consistent way that is reflected in both the living and dying processes. In order to meet this objective, 21 subjects who were currently (or had been) confronted with a life-threatening illness were interviewed and 17 were given the LS/DSQ, an instrument designed to assess Keleman's (1974) concepts of eruptive and congealing response patterns. This chapter will begin with an examination of the limitations of this investigation. The responses to the five research questions will be discussed and the implications of the investigation for (a) continued research, and (b) counselling individuals faced with a life-threatening illness will be presented.

Limitations of the Investigation

The limitations of the investigation related to the sample, the generalizability of the results and the instruments used for collection of the data.

The fact that the sample included two subgroups, those subjects who were currently facing a life-threatening illness and those who had done so in the past, merits attention. Consequently, in those segments of the interview and the LS/DSQ that dealt with response to life-threatening illness, some subjects gave information about their current illnesses and others provided the same information retrospectively. However, no discrepancies were noted between these groups

in the capacity of individuals to identify and discuss facts, behaviors and feelings associated with life-threatening illnesses. This may be related to the fact that all subjects were asked to provide retrospective information during the interview (i.e. in identifying and discussing experiences of change) and were, therefore, accustomed to this process, and subjects chose material that had personal significance for them. However, the retrospective nature of much of the information that was provided merits specific attention. As indicated, in most instances, subjects were asked to provide reconstructed views of events in their lives. These views may or may not have been modified by factors such as the passage of time and subjects' current attitudes toward individual experiences that occurred in the past. They, therefore, cannot necessarily be regarded as accurate accounts of events as they happened but can be treated as accurate reconstructions of events as perceived by subjects at the time they were interviewed. Other limitations related to the sample are explicit. The sample used for this investigation was restricted to those subjects who agreed to voluntary participation in the study and resided in Edmonton. Therefore, caution should be exercised in generalizing the results of this investigation to other populations.

Limitations concerning the instruments used for data collection also exist. The reliability of the interview schedule was not formally estimated nor was it standardized. However, it was believed to provide a valid assessment of subjects' perceptions for several reasons--the uniform way in which it was utilized, the consistency of subjects' responses to it, and the fact that it was designed and used by a researcher with established clinical skills. Statistical evaluation of

the LS/DSQ was not completed since the purpose of the questionnaire was to obtain information about subjects' self-perceptions, not to measure a specific construct. The degree to which the LS/DSQ responses were consistent with individual subjects' interview responses and the researcher's subjective impressions, suggested that it successfully accomplished its goal. Generally, subjects completed the LS/DSQ thoughtfully and without apparent difficulty. However, the terminology used on several individual items was too sophisticated for a few subjects to understand. For example, the researcher was asked on occasion to provide alternate definitions for such words as "frenetic" and "volatile," which may have influenced the response ultimately provided. However, this request was not made frequently enough to create serious question about the overall usefulness of the LS/DSQ.

Discussion of the Research Questions

How Do Subjects Define Change Experiences?

The types of change experiences described by subjects fell into four major categories (relationships, illness, death, and geographical moves), with the first two accounting for 49.99% of the total. While, at first glance, these categorizations appear clear and simple, a look beneath the surface provides another perspective. Despite the uniformity in descriptions of experiences of change, it is essential to reiterate that similar experiences frequently varied in meaning and impact from individual to individual. Thus, one's personal response to a given situation emerged as the most crucial determinant of

whether or not it represented an experience of change. This finding is consistent with the phenomenological approach to human behavior in which behavior is analyzed in the context of the meaning one gives to her/his existence (Forgus & Shulman, 1979). It is also supported in discussions of crisis theory (Calhoun et al., 1972; Ewing, 1978). Caplan's (1964) very definition of crisis, in fact, "refers to one's emotional reaction and not to the situation itself. As such, crises is naturally an individual matter (Ewing, 1978, p. 13).

The importance of the subjective meaning that is placed on an event does not preclude the existence of common denominators in situations that precipitate threat. For example, in many of the change experiences identified in this investigation, loss was a dominant feature (associated with the death of a significant person, a move from one geographical area to another, the termination of an important relationship, or facing the potential loss of one's own life through illness). This trend is supported by Lieberman (1975) and Marris (1974) in their discussions of crisis. To Lieberman, loss (which he described as a disintegration of attachments to persons and things) is "part and parcel of an event that is elevated to crisis proportions" (p. 156) while Marris placed loss in the context of a crisis of discontinuity.

It is apparent that certain characteristics of change experiences as defined by subjects of this study bear similarities to those of crisis defined by crisis theorists. The two major precipitants of crisis described in the literature on crisis are sit-

uational (accidental) and developmental (Caplan, 1964; Hoff, 1978). The former evolves from stressful life events that frequently cannot be prepared for, while developmental crises are normal, anticipated periods of affective and cognitive upset that occur between one stage of development and the next.

The majority of change experiences discussed by the population in this investigation were situational and were often accompanied by feelings of having little or no control over respective situations. Subject 12, for example, associated anger, frustration and lack of control with the onset of her illness and the financial stress she experienced earlier in her life, while subject 10 did not perceive herself as having control over any of the described experiences of change. Developmental change experiences were infrequently mentioned. Subject 3's description of the emotional struggle he experienced upon entering his 40's was, however, one such example.

Crises are also clearly defined as time-limited; they are described by Caplan as lasting from one to five weeks. The specific time limitation placed on the definition of crisis was conspicuous in its absence for most of the charge experiences described in this study. While some had shorter time constraints than others, none fit the descriptive category of several weeks duration. To the contrary, some lasted for a number of years and could be more accurately cast as processes which may, as Keleman (1979) suggested in his discussion of transition, possess distinct phases of their own.

The bases for the facts that (a) change experiences and/or crises are relativistic, and (b) the time frame of experiences of

change defined in this investigation varied from that established by crisis theorists, are open to speculation. It is obvious that some people are more prone than others to perceive given situations as crises. When considering the reason for this difference, one explanation may rest in the interactional system of the person involved (Vander Well, 1980). How, for example, are the persons in one's immediate environment reacting to the manner in which s/he is responding to and handling the stressful situation? What would be different if the situation were not interpreted and acted upon as a crisis? In short, are some needs of the system, as well as the individual in crisis, being met by the crisis and, perhaps, by its perpetuation? This possibility offers one interpretation for the behavior of those individuals and systems (i.e. families), frequently seen in counselling, who have a penchant for creating crises and seem to thrive on their very existence. One can only speculate, as well, about the fact that the time-limited nature of crisis described by crisis theorists was not found to exist in the current study. One explanation is that the population used in this study differed from that used by crisis theorists. Crisis theory, which is closely intertwined with intervention procedures, evolved from direct work with people in crisis who received professional assistance. The subjects of this study generally were not recipients of this type of help. Therefore, there was more room for spontaneous recovery as well as for trial-and-error resolution of the crisis (which may have taken more time). There is also the remote possibility that the crisis counsellors' emphasis on

the concept of homeostasis may have encouraged the establishment of a time structure that is more consistent with their own theoretical viewpoint than with the individual reality of persons in crisis.

One other aspect of the nature of the change experiences defined by this population, separate from the concept of crisis, is open to consideration. Conspicuous in their absence were change experiences that traditionally would be regarded as positive, happy events--i.e. marriage, the birth of a child, graduation from school. One explanation of this phenomenon rests in the possibility that a "set" may have been created on initial contact and in the interview with the subjects (Appendix D) that fostered a negative view of change. For example, the fact that subjects knew that the interview would focus, in part, on confrontation with a life-threatening illness may have had the impact of casting experiences of change in a negative framework and de-emphasizing a more positive definition of such life events.

Do Identifiable Coping Patterns Emerge in Response to Change?

The results of this study suggested there are identifiable behavioral and affective patterns that characterized most subjects' reactions to change. On the LS/DSQ, for example, two major patterns emerged for 13 of the 17 subjects who completed the questionnaire. On the basis of these results, the subjects were labelled eruptors (outer-directed) and congealers (inner-directed). In summary, the eruptors had a positive, future and people-oriented life view and appeared to have maintained a high level of involvement in their described ex-

periences of change. The congealers, on the other hand, tended to be more oriented toward the past than the present, had a passive relationship to change experiences, generally defined them in negative terms and were inclined to withdraw further into self under stress. Another group of subjects, those who dealt with change in a concrete, practical way, was analyzed on the basis of the interview data alone. The behavioral description of the persons in this group bore a strong similarity to that of the eruptors.

The descriptions of the subjects of this study as eruptive and congealing resemble other psychological constructs such as Rotter's (1966) concept of locus of control and Jung's (1928) theory of psychological types in which Jung outlined the personality characteristics of the introvert and extravert. To examine the similarities between Rotter's internally and externally controlled person, Jung's introvert and extravert and the eruptors and congealers of this study might add another dimension to this discussion. However, the relevance of the similarities between these descriptive categories rests in another area. It brings to the fore the reality that eruptive and congealing patterns are not unique unto themselves but are likely aligned with other categorizations that have long been a familiar component of personality theory.

Upon further examination of the eruptive and congealing response patterns another question emerged. Why, out of the 17 subjects who completed the LS/DSQ, were there only four eruptors and more than twice as many (nine) congealers? While the small sample size might have affected these results, other possibilities that can best be addressed in the form of questions exist. Are the characteristics of the mixed

group sufficiently similar to those of the eruptors to consider eight subjects (four eruptors and four in the mixed group) as eruptors? On the other hand, is the LS/DSQ description of four eruptors and nine congealers reflective of a typical population ratio? Are congealers, for reasons related to the associations between emotions and disease (LeShan, 1977), more susceptible to life-threatening illnesses and, consequently, more numerous than the eruptors? Do they have a stronger need to talk about their illnesses (in comparison to the eruptors) and were they, therefore, more accessible? Are congealing behaviors more acceptable in terms of societal norms and does the socialization process produce more congealers than eruptors? In relation to the last question, consider again the behavioral description of the congealers. They were more passive than active, frequently relied on external cues in determining their behavior, and, in terms of the results of this study, were frequently "caregivers." In effect, they could be cast as the "nice guys" of society. It, therefore, doesn't seem unreasonable to speculate whether society, as a whole, places a positive value on these behaviors and, thereby, reinforces them more stringently than it does the self-determining, active behaviors of the eruptors.

Does Consistency Exist in the Manner that Subjects Respond to General Life Change Experiences and those that are Related to Life-Threatening Illnesses?

In order to address this question, a differentiation must be made between overall trend displayed by the subjects of this study and their individual patterns of response. The former suggested that there was a consistent response to change, coping with life-threatening

illnesses included, and subjects perceived themselves as responding to change in a reasonably consistent fashion. For example, those subjects with a passive response pattern maintained it throughout all experiences of change. This trend gained additional support from an overview of those subjects who reported life style changes as result of confrontation with a life-threatening illness. Despite the fact that behavioral changes occurred and, in some cases, values were realigned, there was no indication that there were radical shifts in these subjects' general patterns of functioning.

Less consistency was found in the manner in which some subjects perceived change experiences and their outcome, particularly when the congealers and eruptors were compared. The eruptors were highly consistent in the manner in which they viewed all experiences of change, including those related to life-threatening illness; they perceived such experiences in a positive light (or indicated individual change experiences had both positive and negative components), and, as a result of these experiences, always described themselves as evolving in a positive direction. The congealers were less consistent, viewed life change experiences and those associated with life-threatening illnesses as negative more often than positive and as a result of having had such experiences, perceived themselves as not changing at all or as having changed in either a positive or negative direction. For example, for subject 7 each change experience had a different outcome--#1 had a sobering effect, #2 made her emotionally stronger, #3 increased her appreciation for young people, and #4 made it difficult for her to get close to anyone again while having a life-threatening

illness was not perceived as an experience of change at all.

The above findings are consistent with the view that the outcome of crisis can evolve in a psychologically positive or negative direction (Caplan, 1964; Moos, 1975) and, to a considerable degree, with Dabrowski's (1964) theory of positive disintegration. Positive disintegration, similar in definition to that of crisis, is regarded by Dabrowski as a generally positive developmental process and is described as such when it widens the horizon, enriches life and promotes creativity; it is negative when it causes involution or has no developmental effects. However, his belief was that in most instances the outcome is positive, a view that was supported by the overall trend of this study but not by the outcome of some change situations identified by the congealers. One must look beyond the theoretical framework, however, to examine possible reasons for these results. Why were the eruptors so consistent in their relationships to change and why were more inconsistencies found in response to change among the congealers? One possibility rests in the perception of self in relation to the environment. Eruptors, as indicated, were active participants in experiences of change, maintained control over these experiences and, even when faced with a life-threatening illness, perceived themselves as such. Conversely, the congealers viewed themselves as victims whose behavioral adaptations to change were passive and who often felt that they were at the mercy of circumstances beyond their control. Consequently, the tendency toward reliance on external factors to cope with given change situations was greater than it was for the eruptors. Reactions to change for the congealers, then, would be

likely to be contingent not only on the nature of the experience (Moos, 1976) but on the external resources available at the time. Thus, outcome could vary from one situation to another, depending on the tenor of the environmental situation and whether it hindered or enhanced a positive adaptation to change.

What Subject Attitudes and Behaviors Emerge in Relation to the Prospect of One's Personal Dying Process?

Eighty-six percent of the subjects defined confrontation with an illness that threatened their lives as an experience of change while only 24 percent expressed a fear of dying. Subjects reacted to the prospect of dying in several ways. Some redefined personal values as a result of having been faced with a life-threatening illness while others modified their life styles in manners they believed would increase their chances of survival. A number of subjects handled feelings about death and dying in the context of a specific religious framework and, for a few, having a life-threatening illness was not reported to have strong emotional impact.

At first glance there appears to be an obvious inconsistency in the above results in that a minority of the subjects stated they were afraid of dying while a majority defined exposure to a life-threatening illness as a change event. It is highly unlikely that this phenomenon can be explained on the basis of the fact that subjects didn't associate the illness with the possibility of dying, since all had considered dying to be imminent at some point during their respective illnesses. However, there are other possible explanations. Many subjects described the time surrounding the initial diagnosis as the

period of greatest emotional upheaval. It would have been at this time that the fear of the unknown (i.e. the potential course of the illness, response to medication, prognosis) would have been at its peak. It is conceivable that in the course of adjusting to their illnesses over time subjects also came to terms with the prospect of dying and the meaning it held for the manner in which they continued to live their lives.

Three other factors, (a) the age of the subjects, (b) the possibility that denial was operating in some cases, and (c) the consideration that dying was not a potentially fearful experience for many, offer other explanations for the infrequent identification of the fear of dying. Fifty-seven percent of the population interviewed was over 50 years of age. If one accepts the premise that fears associated with death and dying decrease with age (Bengston et al., 1977; Feifel & Branscomb, 1973), the age factor may have affected these results. On another level, denial of this fear may have been present but could not be pinpointed by the methods used in this study. There were two specific instances in which one could speculate whether fear of dying was present but was overtly denied (subject 14, in response to the question of whether he was afraid of dying, answered negatively but quickly added that his doctors maintained he was "subconsciously" afraid; in response to the same question, subject 5 jokingly said he wasn't ever going to die and then stated he would likely be shot to death by a jealous husband at age 95). As well, consideration of the possibility that subjects were simply not afraid of the process of dying cannot be neglected. Perhaps, if subjects had been asked "Are

you afraid of death?" instead of "Are you afraid of dying?" very different responses would have been elicited.

In examining specific behaviors and attitudes associated with the prospect of dying it seems that frequently modes were chosen that would enhance subjects' feelings of personal control either by taking direct control themselves through decision-making and behavioral changes (subjects 3, 11, 12, 18) or giving the control to an external source in which they had faith (subjects 1, 4, 13, 21). Reliance on a fundamental religious framework was the most obvious example of the latter tendency. The dependence on a religious structure, however, was not characteristic of subjects of all religious orientations, no matter how religious they proclaimed themselves to be, but was more likely to occur when the religion bore the characteristics of Allport's (1968) intrinsic faith (i.e. one in which religious beliefs are internalized and one's primary motives are located in religion). It seems obvious from the above, that whatever modes were chosen for handling the prospect of dying, they were always consistent with subjects' individual value systems, did not vary dramatically from overall patterns of coping with change and, basically, were in line with the personality characteristics unique to each individual.

Is Keleman's (1974) Description of Eruptive and Congealing Response Patterns a Useful One in Assessing Reactions to Change?

Keleman's description of eruptive and congealing patterns of response, as reflected in the LS/DSQ, obviously had an important function since it provided valuable material on subjects' self-perceptions. It also served as a "check" on the interview data with which, for the

most part, it was found to be consistent. In its current form, the LS/DSQ was generally completed without difficulty other than in regard to some of the terminology (previously described) and seemed to be an easy questionnaire to fill out in a relatively short period of time. Beyond its overall function in this study, however, it contributed information in the area of personality typologies that appears related to more established constructs. This association seems worthwhile evaluating through more formal statistical procedures. Without validation, the usefulness of the LS/DSQ as an instrument in psychological research is limited. Whether, in fact, it does measure those traits associated with eruptive and congealing styles of life expression can only be speculative.

Implications

Implications for Research

The current investigation was designed to assess the relationship between the response to dying as a change experience and the manner in which other experiences of change in the living process were handled. The findings of this study are specific to the particular sample and the researcher (as an "instrument" of the study) and should not be generalized to other populations without replication of the study with similar populations under similar conditions.

Research in the area of death and dying has yielded contradictory results in many areas and has been widely criticized for its methodology, particularly the instruments used in studies with this focus. The current study approached an examination of response to dying from the specific perspective of its relationship to the living process. As

such, it placed reactions to dying within the context of patterns of response and left as much room for the identification of individual patterns as it did for those that were more global.

During the course of this investigation it became clear that a major value of the type of research conducted was that it made allowances for unexpected, unanticipated outcomes as well as for those that were being investigated more directly. The former evolved in the course of the research process. This process, thereby, became a significant aspect of the study and the serendipitous discoveries that emerged were an integral function of this investigative procedure. It is obvious that this type of information would not have been accessible if more traditional methods of inquiry (i.e. specific psychometric instruments, a question-answer interview format) had been used. Related to the above is the role of the researcher and, equally important, the researcher's own perception of her/his role in data collection. The researcher, in this investigation, clearly functioned as an open observer (listening, exploring, questioning, clarifying) as opposed to that of a focused observer whose function whould be to obtain specific information in a more circumscribed fashion.

Implications for Counselling

The results of this investigation have general implications for counselling that relate to (a) the overall usefulness of the interview format for counselling purposes, and (b) the congealing and eruptive categorizations.

The interview schedule was the primary method of identifying response patterns in the subjects of this study. As the interview

was conducted, it also provided an avenue for the development of insight into patterns of behavior for some of the subjects, a phenomenon that frequently occurs at some point in the course of counselling but often takes more time. One subject, for example, spontaneously stated at the end of the interview that she was going to change her life style, despite the fact that the researcher had not used the term "life style" during the interview. Subject 18 specifically identified the interview as providing the opportunity for a life assessment procedure: "It makes one start . . . to assess his life. You think more about it because you're talking objectively to another person. It probably solidifies your thoughts . . . It confirms what you were thinking." This procedure, referred to in the literature as the life review process, is frequently regarded as being more marked in the aged (Butler, 1963). However, one cannot discount the fact that it may be a "response to crises of various types" (Butler, 1963, p. 66) of which imminent death may be one instance. While this process is often described as one that occurs naturally, the possibility that it may also have value when it is used as a specific component of counselling procedures should not be ignored. Additional information would be required, however, before one could assume that it also may serve a useful purpose in counselling those individuals that are not concerned with response to life crises and/or life-threatening illnesses.

The response of the subjects to the interview itself also contributed information on its personal value for individuals confronted with a life-threatening illness. One of the motivating factors for

the subjects' agreement to participate in this study seemed closely related to the wish to be of help to others. For example, they made such comments as "I hope you feel I have contributed" (subject 3), "I only hope that I've given you something that is of benefit to you" (subject 14), "I would be really happy if it helps you out" (subject 21). One can speculate that offering something that is of value to others is an especially important opportunity for a group of people who, as a result of their illnesses, have been at the receiving end of the helper-helpee continuum.

Having utilized the interview schedule, as well as the LS/DSQ, to identify the congealing and eruptive characteristics of the subjects of this study, what connection do these descriptive categories have to counselling? This study, as does all research in counselling, has dealt with generalities (the identification of two major patterns of response) while counselling, by virtue of its nature, deals with the particular (the person as an individual). This general/particular dichotomy, when considered in the context of the counselling process, presents a fundamental dilemma that is essential for the counsellor to consider. How much emphasis can be placed on the general (in this case, the eruptive and congealing categories) without clouding or losing sight of the uniqueness of the individual?

Evolving from the discussion of the descriptive categories of this study are some implicit assumptions about how they can be useful to counsellors. However, since this was not a study of the counselling process, nor were the subjects of the study "clients" in the traditional sense, it would be presumptuous to translate these

assumptions into an explicit form. What remains clear, however, is that these types of categories may lead to varying counsellor expectations and hypotheses concerning treatment. One cannot assume, however, that such hypotheses and expectations will remain consistent from counsellor to counsellor but may vary in line with the individual counsellor's interpretation of the categories, the theoretical orientation of the counsellor and whether, in fact s/he functions from an eruptive or congealing personal framework.

REFERENCES

Adler, A. The science of living. London: George Allen & Unwin, 1952 (Originally published, 1930.)

Aguilera, D. C., Messick, J. M., & Farrell, M.S. Crisis intervention: Theory and methodology. St. Louis: C. V. Mosby, 1970.

Alexander, I. E., & Adlerstein, A. M. Death and religion. In H. Feifel (Ed.), The meaning of death. New York: McGraw-Hill, 1959.

Alexander, I. E., Colley, R. S., & Adlerstein, A. M. Is death a matter of indifference? In R. Fulton (Ed.), Death and identity. New York: John Wiley, 1965. (Reprinted from The Journal of Psychology, 1957, 43.)

Allport, G. W. The open system in personality theory. Journal of Abnormal and Social Psychology, 1960, 61, 301-310.

Allport, G. W. Pattern and growth in personality. New York: Holt, Rinehart & Winston, 1961.

Allport, G. W. The person in psychology. Boston: Beacon Press, 1968.

Allport, G.W. Personality: A psychological interpretation. London: Constable, 1971. (Originally published, 1937.)

Allport, G.W., Bruner, J. S., & Jandorf, E. M. Personality under social catastrophe. In C. Kluckhohn & H. A. Murray (Eds.), Personality in nature, society, and culture. New York: Alfred A. Knopf, 1955. (Reprinted from Character and Personality, 1941, 10.)

Ansbacher, H. L. Life style: A historical and systematic review. Journal of Individual Psychology, 1967, 23, 191-216.

Ansbacher, H. L., & Ansbacher, R. R. The individual psychology of Alfred Adler. New York: Basic Books, 1956.

Atchley, R. C. The social forces in later life (2nd ed.). Belmont, Calif.: Wadsworth, 1977.

Baldwin, B. A. A paradigm for the classification of emotional crisis: Implications for crisis intervention. American Journal of Orthopsychiatry, 1978, 48, 538-551.

Becker, E. The denial of death. New York: The Free Press, 1973.

Becker, H. S. Problems of inference and proof in participant observation. American Sociological Review, 1958, 23, 652-660.

Becker, H., & Bruner, D. K. Attitudes toward death and the dead. Mental Hygiene, 1931, 15, 828-837.

Bengston, V. L., Cuellar, J. B., & Ragan, P. K. Stratum contrasts and similarities in attitudes toward death. Journal of Gerontology, 1977, 32, 76-88.

Bischof, L. J. Interpreting personality theories. New York: Harper & Row, 1964.

Boyar, J. I. The construction and partial validation of a scale for the measurement of the fear of death (Doctoral dissertation, University of Rochester, 1964). Dissertation Abstracts, 1964, 25, 2041.

Bühler, C. The developmental structure of goal setting in group and individual studies. In C. Bühler & F. Massarik (Eds.), The course of human life. New York: Springer, 1968.

Bühler, C., & Goldenberg, H. Structural aspects of the individual's history. In C. Bühler & F. Massarik (Eds.), The course of human life. New York: Springer, 1968.

Butler, R. N. Life review and interpretation of reminiscence in the aged. Psychiatry, 1963, 26, 65-76.

Calhoun, L. G. Shelby, J., & King, H. F. Dealing with crisis: A guide to critical life problems. Englewood Cliffs, N. J.: Prentice-Hall, 1972.

Caplan, G. Principles of preventive psychiatry. London: Tavistock, 1964.

Cappon, D. The dying. Psychiatric Quarterly, 1959, 33, 466-489.

Chiappetta, W., Floyd, H. H., Jr., & McSeveney, D.R. Sex differences in coping with death anxiety. Psychological Reports, 1976, 39, 945-946.

Choron, J. Modern man and mortality. New York: Macmillan, 1964.

Christ, A. E. Attitudes toward death among a group of acute geriatric and psychiatric patients. In R. Fulton (Ed.), Death and identity. New York: John Wiley, 1965. (Reprinted from Journal of Gerontology, 1961, 16.)

Collett, L. J., & Lester, D. The fear of death and the fear of dying. The Journal of Psychology, 1969, 72, 179-181.

Croake, J. W. An Adlerian view of life style. Journal of Clinical Psychology, 1975, 31, 513-518.

Dabrowski, K. Positive disintegration. Boston: Little, Brown, 1964.

Dickstein, L. Attitudes toward death, anxiety and social desirability. Omega, 1978, 8, 369-378.

Diggory, J. C., & Rothman, D. C. Values destroyed by death. In R. Fulton (Ed.), Death and identity. New York: John Wiley, 1965. (Reprinted from Journal of Abnormal and Social Psychology, 1961, 63.)

Duckworth, D. Human coping processes. In J. Adams, J. Hayes, & B. Hopson (Eds.), Transition: Understanding and managing personal change. London: Martin Robinson, 1976.

Duke, E. H. Meaning in life and acceptance of death in terminally ill patients (Doctoral dissertation, Northwestern University, 1977). Dissertation Abstracts International, 1978, 38, 3874B-3875B.

Durlak, J. A. Relationship between individual attitudes toward life and death. Journal of Consulting and Clinical Psychology, 1972, 38, 463.

Eastham, K., Coates, D., & Allodi, F. The concept of crisis. Canadian Psychiatric Association Journal, 1970, 15, 463.

Erikson, E. H. Childhood and society (2nd ed.). New York: W.W. Norton, 1963.

Erikson, E. H. Identity: Youth and crisis. New York: W.W. Norton, 1968.

Everts, P. L. Differences in fear of death among self-actualized, intrinsically-religious groups and a control group (Doctoral dissertation, Fuller Theological Seminary, 1978). Dissertation Abstracts International, 1978, 39, 2473B-2474B.

Ewing, C. P. Crisis intervention as therapy. New York: Oxford University Press, 1978.

Feifel, H. Attitudes toward death in some normal and mentally ill populations. In H. Feifel (Ed.), The meaning of death. New York: McGraw-Hill, 1959.

Feifel, H. Attitudes toward death: A psychological perspective. Journal of Consulting and Clinical Psychology, 1969, 33, 292-295.

Feifel, H. Religious conviction and fear of death among the healthy and terminally ill. Journal for the Scientific Study of Religion, 1974, 13, 353-360.

Feifel, H., & Branscomb, A. B. Who's afraid of death? Journal of Abnormal Psychology, 1973, 81, 282-288.

Fisher, G. Death, identity and creativity. Omega, 1971, 2, 303-306. (Reprinted from Voices, 1969, 5.)

Forer, B. R. The therapeutic value of crisis. Psychological Reports, 1963, 13, 275-281.

Forgus, R., & Shulman, B. H. Personality: A cognitive view. Englewood Cliffs, N. J.: Prentice-Hall, 1979.

Freud, S. [Thoughts for the times on war and death.] In E. Jones (Ed.), Sigmund Freud: Collected papers. New York: Basic Books, 1960. (Originally published, 1915.)

Fromm, E. The heart of man. New York: Harper & Row, 1964.

Goldstein, K. The organism. New York: American Book, 1939.

Guthrie, G. P. The meaning of death. Omega, 1971, 2, 299-302. (Reprinted from Voices, 1969, 5.)

Hall, C. S., & Lindzey, G. L. Theories of personality. New York: John Wiley, 1957.

Hinton, J. M. The physical and mental distress of the dying. Quarterly Journal of Medicine, 1963, 32, 1-21.

Hinton, J. Dying, Baltimore: Penguin, 1971.

Hoff, L. A. People in crisis: Understanding and helping. Menlo Park, Calif.: Addison-Wesley, 1978.

Hopson, B., & Adams, J. Toward an understanding of transition: Defining some boundaries of transition dynamics. In J. Adams, J. Hayes, & B. Hopson (Eds.), Transition: Understanding and managing personal change. London: Martin Robinson, 1976.

Hutchnecker, A. A. Personality factors in dying patients. In H. Feifel (Ed.), The meaning of death. New York: McGraw-Hill, 1959.

Imara, M. Dying as the last stage of growth. In E. Kübler-Ross (Ed.), Death: The final stage of growth. Englewood Cliffs, N. J.: Prentice-Hall, 1975.

Jacques, E. Death and the mid-life crisis. International Journal of Psychoanalysis, 1965, 46, 502-513.

Jeffers, F. C., Nichols, C. R., & Eisdorfer, C. Attitude of older persons toward death: A preliminary study. Journal of Gerontology, 1961, 16, 53-56.

Jeffers, F. C., & Verwoerdt, A. How the old face death. In E. W. Busse & E. Pfeiffer (Eds.), Behavior and adaptation in late life. Boston: Little, Brown, 1969.

Jourard, S. M. Personal adjustment (2nd ed.). London: Macmillan, 1963.

Jung, C. G. [Two essays on analytical psychology.] London: Baillier, Tindall & Cox, 1928.

Jung, C. G. [The soul and death.] In H. Feifel (Ed.), The meaning of death. New York: McGraw-Hill, 1959. (Reprinted from Wirklichkeit der Seele, 1934.)

Kahoe, R. D., & Dunn, R. F. The fear of death and religious attitudes and behavior. Journal for the Scientific Study of Religion, 1975, 14, 379-382.

Kalish, R. A. Death and dying in a social context. In R. H. Binstock & E. Shanas (Eds.), Handbook of aging and the social sciences. New York: Van Nostrand Reinhold, 1976.

Kastenbaum, R. The mental life of dying geriatric patients. The Gerontologist, 1967, 7, 97-100.

Kastenbaum, R. Is death a life crisis? On the confrontation with death in theory and practice. In N. Datan & L. H. Ginsberge (EDS.), Life-span developmental psychology: Normative life crises. New York: Academic Press, 1975.

Kastenbaum, R., & Aisenberg, R. The psychology of death. New York: Springer, 1972.

Kastenbaum, R., & Aisenberg, R. The psychology of death (Concise ed.). New York: Springer, 1976.

Kastenbaum, R., & Costa, P. T., Jr. Psychological perspectives on death. Annual Review of Psychology, 1977, 28, 225-249.

Keleman, S. Living your dying. New York: Random House, 1974.

Keleman, S. Somatic reality. Berkeley, Calif.: Center Press, 1979.

Kimmel, D. C. Adulthood and aging. New York: John Wiley, 1974.

Klug, L. An empirical investigation of the relationship between self-actualization and reconciliation with death. Unpublished doctoral dissertation, University of Ottawa, 1976.

Koestenbaum, P. The vitality of death. Omega, 1971, 2, 253-271. (Reprinted from The Journal of Existentialism, 1964, 18.)

Koestenbaum, P. Is there an answer to death? Englewood Cliffs, N.J.: Prentice-Hall, 1976.

Kübler-Ross, E. On death and dying. New York: Macmillan, 1969.

Kübler-Ross, E., Braga, L., & Braga, J. Omega. In E. Kübler-Ross (Ed.), Death: The final stage of growth. Englewood Cliffs, N.J.: Prentice-Hall, 1975.

Lazarus, R. S. Psychological stress and the coping process. New York: McGraw-Hill, 1966.

LeShan, L. You can fight for your life. New York: Jove, 1977.

Lester, D. Experimental and correlational studies of the fear of death. Psychological Bulletin, 1967, 65, 27-36.

Lester, D. Studies in death attitudes: Part two. Psychological Reports, 1972, 30, 440.

Lieberman, M. A. Psychological correlates of impending death. Journal of Gerontology, 1964, 20, 181-190.

Lieberman, M. A. Adaptive processes in late life. In N. Datan & L. H. Ginsberg (Eds.), Life-span developmental psychology: Normative life crises. New York: Academic Press, 1975.

Loeb, M. B. Adaptation and survival: New meanings in old age. In N. Datan & L. H. Ginsberg (Eds.), Life-span developmental psychology: Normative life crises. New York: Academic Press, 1975.

Long, L. M. K. Alfred Adler and Gordon W. Allport: A comparison on certain topics in personality theory. American Journal of Individual Psychology, 1952, 10, 48-53.

Marris, P. Loss and change. London: Routledge & Kegan Paul, 1974.

Martin, D., & Wrightsman, L. S. Religion and fears about death: A critical review of research. Religious Education, 1964, 59, 174-176.

May, R. The meaning of anxiety. New York: Ronald Press, 1950.

May, R. Contributions of existential psychotherapy. In R. May, E. Angel & H. F. Ellenberger (Eds.), Existence: A new dimension in psychiatry and psychology. New York: Basic Books, 1959.

Middleton, W. C. Some reactions toward death among college students. Journal of Abnormal and Social Psychology, 1936, 31, 165-173.

Mikawa, J. K. An alternative to current analyses of suicidal behavior. Psychological Reports, 1973, 32, 323-330.

Miller, K. S., & Iscoe, I. The concept of crisis. Human Organization, 1963, 22, 195-201.

Minton, B., & Spilka, B. Perspectives on death in relation to powerlessness and form of personal religion. Omega, 1976, 7, 261-268.

Mischel, W. Continuity and change in personality. American Psychologist, 1969, 24, 1012-1018.

Moos, R. H. Human adaptation. Lexington, Mass.: Lexington, 1976.

Moriarty, A. E., & Toussieng, P. W. Adolescence in a time of transition. Bulletin of the Menninger Clinic, 1975, 39, 391-408

Moustakas, C. E. Turning points. Englewood Cliffs, N. J.: Prentice-Hall, 1977.

Munroe, R. L. Schools of psychoanalytic thought. New York: Dryden, 1955.

Parad, H. J., & Caplan, G. A framework for studying families in crisis. In H. J. Parad (Ed.), Crisis intervention: Selected readings. New York: Family Service Association of America, 1965. (Reprinted from Social Work, 1960, 5.)

Pollack, D. Crisis and response in college students. Journal of Abnormal Psychology, 1971, 78, 49-51.

Rank, O. The trauma of birth. New York: Robert Brunner, 1952.

Rapoprt, L. The state of crisis: Some theoretical considerations. In H. J. Parad (Ed.), Crisis intervention: Selected readings. New York: Family Service Association of America, 1965. (Reprinted from The Social Service Review, 1962, 36.)

Rhudick, P. J., & Dibner, A. S. Age, personality and health correlates of death concerns in normal aged individuals. In R. Fulton (Ed.), Death and identity. New York: John Wiley, 1965. (Reprinted from Journal of Gerontology, 1961, 16.)

Riegel, K. F. Adult life crises: A dialectic interpretation of development. In N. Datan & L. H. Ginsberg (Eds.), Life-span developmental psychology: Normative life crises. New York: Academic Press, 1975.

Rotter, J. B. Generalized expectancies for internal versus external control of reinforcement. Psychological Monographs: General and Applied, 1966, 80, 1-28.

Russell, B. Do we survive death? In E. S. Schneidman (Ed.), Death: Current Perspectives. Palo Alto, Calif.: Mayfield, 1976. (Originally published, 1936.)

Schneidmann, E. S. Orientations toward death: A vital aspect of the study of lives. In R. W. White (Ed.), The study of lives. New York: Atherton Press, 1963.

Schulz, R., & Aderman, D. Clinical research and the stages of dying. Omega, 1974, 5, 137-143.

Sheehy, G. Passages: Predictable crises of adult life. New York: Bantam, 1977.

Swenson, W. M. Attitudes toward death among the aged. In R. Fulton (Ed.), Death and identity. New York: John Wiley, 1965. (Reprinted from Minnesota Medicine, 1959, 42.)

Swenson, W. M. Attitudes toward death in an aged population. Journal of Gerontology, 1961, 16, 49-52.

Taplin, J. R. Crisis theory: Critique and reformulation. Community Mental Health Journal, 1971, 7, 13-23.

Templer, D. I. The construction and validation of a death anxiety scale. Journal of General Psychology, 1970, 82, 895-897.

Templer, D. I. Death anxiety in religiously very involved persons. Psychological Reports, 1972, 31, 361-362.

Templer, D. I., & Dotson, E. Religious correlates of death anxiety. Psychological Reports, 1970, 26, 895-897.

Templer, D. I., Lester, D., & Ruff, C. F. Fear of death and femininity. Psychological Reports, 1974, 35, 530.

Templer, D. I., Ruff, C. F., & Franks, C. M. Death anxiety: Age, sex and parental resemblance in diverse populations. Developmental Psychology, 1971, 4, 108.

Vander Well, A. R. Personal communication, July 23, 1980.

Vernon, G. M. Sociology of death: An analysis of death-related behavior. New York: Ronald Press, 1970.

Wahl, C. W. The fear of death. In H. Feifel (Ed.), The meaning of death. New York: McGraw-Hill, 1959.

Wallace, S. H. Attitudes of college students toward death (Doctoral dissertation, Claremont Graduate School, 1976). Dissertation Abstracts International, 1976, 37, 208A-209A.

Weisman, A. D. On dying and denying: A psychiatric study of terminality. New York: Behavioral Publications, 1972.

Wilder, J. Basimetric approach to psychiatry. In S. Arieti (Ed.), American handbook of psychiatry. New York: Basic Books, 1966.

Williams, R. H., & Wirths, C. G. Lives through the years. New York: Atherton Press, 1965.

Zilboorg, G. Fear of death. The Psychoanalytic Quarterly, 1943. 12, 465-475.

APPENDIX A

CONSENT FORM FOR SUBJECTS REFERRED BY THE CITY OF EDMONTON HOME CARE SERVICE PROGRAM

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY
FACULTY OF EDUCATION
THE UNIVERSITY OF ALBERTA

I, _____, voluntarily consent to participate in an interview with Rosemary Liburd, a graduate student in the Faculty of Graduate Studies, Educational Psychology Department, University of Alberta. I understand that the information I provide will be used for a Ph.D. dissertation and will be treated as confidential.

I also give permission to Rosemary Liburd to share pertinent information discussed in the interview with the Edmonton Home Care case co-ordinator, provided this plan is discussed with me in advance.

Date_____ Signed_____

Witness_____

6-102 EDUCATION NORTH, EDMONTON, ALBERTA, CANADA • T6G 2G5 • TELEPHONE (403) 432-5245

APPENDIX B

LETTER TO THE DIRECTOR, CITY OF EDMONTON HOME CARE SERVICES PROGRAM CONFIRMING REFERRAL ARRANGEMENTS

7412 - 119 Street
Edmonton, Alberta
T6G 1W1
October 31, 1979

Mr. J. Barry Worsfold, Co-ordinator
Edmonton Home Care Program
6th floor, C.N. Tower
10004 - 104 Avenue
Edmonton, Alberta T5J OK1

Dear Mr. Worsfold,

I am writing to confirm the plans we made on October 15th relating to your agreement to provide terminally ill subjects to be interviewed for my dissertation on styles of living and dying.

It is my understanding that:

1. The Home Care Program will provide 20 subjects (10 male and 10 female).
2. I will devise a consent form to be signed by the subjects, giving their consent to participate in the study voluntarily and providing permission for me to communicate any pertinent information evolving out of the interview to the Home Care worker.
3. I will share the results of my study with the Home Care Program staff in the form of a verbal presentation.

I want to express my appreciation for your cooperation and assistance. I am looking forward to meeting with you again on November 5th.

Yours sincerely,

Rosemary Liburd

APPENDIX C

CONSENT FORM FOR SUBJECTS NOT REFERRED BY THE CITY OF EDMONTON HOME CARE SERVICE PROGRAM

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY
FACULTY OF EDUCATION
THE UNIVERSITY OF ALBERTA

I, _____, voluntarily consent to participate in an interview with Rosemary Liburd, a graduate student in the Faculty of Graduate Studies, Educational Psychology Department, University of Alberta. I understand that the information I provide will be used for a Ph.D. dissertation and will be treated as confidential.

Date _____ Signed _____

Witness _____

6-102 EDUCATION NORTH, EDMONTON, ALBERTA, CANADA • T6G 2G5 • TELEPHONE (403) 432-5245

APPENDIX D

INTERVIEW SCHEDULE

INTERVIEW SCHEDULE

Age
Educational Level
Marital Status
Children (Number, Age, Sex)
Occupational History
Information on family of origin
Religion (if any)
Active or inactive member of religious community
Belief in after-life
Diagnosis
Prognosis

1. I am doing a study that involves talking with people who have (had) a terminal illness and view (viewed) themselves as dying so I can learn more about what this process is like and be able to help others. I am interested in talking with you about your experience of illness (or dying) as well as about certain experiences you have had in your life. Whatever information you share with me will be regarded as confidential. Would you be willing to spend some time with me to talk about yourself in this way?

2. Let me explain how I would like to begin. There are certain times in all people's lives that are different from others. Life doesn't seem to go on as smoothly as before and new adjustments are often necessary. In fact, changes in people's lives often results from these kinds of experiences. These experiences can be positive or negative.
   a) Do you have any questions about the kinds of experiences I mean?
   b) Can you remember any such periods in your life? Take your time and see if you can come up with some that are important to you.
   c) You may choose the ones that occurred as recently or far back in your life as you wish.
   d) If subject does not identify any such experiences, some examples will be given.

3. <u>Questions related to change experiences</u>

   a) Please describe this experience more fully.
   b) Would you describe this experience as a positive or negative one for you?
   c) Was it resolved (worked through)? Can you tell me more about that?
   d) Would you describe this experience as a public or private matter?
   e) Why do you think this experience happened?
   f) Can you identify the main feeling you had when this experience occurred?
   g) How did you handle it?
   h) Looking back, are you satisfied or dissatisfied with the way things worked out?

i) If you had the chance to re-live this experience, would you do anything differently? If so, what? How would you do that?
j) Did you change as a result of this experience? If so, in what way?

4. Questions related to terminal illness and dying as a change experience

a) Do (did) you identify the stage in your life in which you regard (regarded) yourself as terminally ill or dying as an experience such as I have described--one in which things aren't (weren't) going so smoothly, in which new adjustments are (were) required and changes in your life are resulting (resulted)?
b) Can you tell me more about that?
c) Are (were) there any positive aspects to it?
d) How are (did) you handling (handle) it?
e) What aspects of your life as it is right now (was then) are (were) particularly important to you?
f) To what or whom do (did) you attribute the fact that you are (were) terminally ill?
g) Would you describe what is (has) happening (happened) to you as a public or private matter?
h) Are (were) other people helpful or unhelpful to you? Tell me more.
i) What is (was) the major way in which you are (were) spending your time?
j) Are (did) you changing (change) as a result of this experience?
k) What is the major feeling you have when you think about dying?
l) Are you afraid of dying?
m) How do you expect to die?
n) If you could die exactly as you choose, what would this type of dying be like?
   (i) Where would it be?
   (ii) Would you prefer to die alone or in the presence of others?
   (iii) Would you prefer your dying to occur rapidly or slowly?
   (iv) Do you consider suicide to be an acceptable alternative as a way of dying for yourself?

5. Can you think of times in your life when you wanted things to change but found this difficult or impossible to accomplish?

6. Do you have any comments you would like to share with me about what this interview was like for you?

APPENDIX E

RESUME OF THE RESEARCHER'S WORK EXPERIENCE AND ACADEMIC QUALIFICATIONS

NAME: ROSEMARY LIBURD

POST-SECONDARY EDUCATION AND DEGREES

Queens College
Flushing, New York
B.A.

University of Pennsylvania
Philadelphia, Pa.
M.S.W.

University of Alberta
Educational Psychology Department
Ph.D. Candidate

Summer Institute in Counselling Girls and Women
University of Pennsylvania
Graduate School of Education
Philadelphia, Pa.

RELATED WORK EXPERIENCE

Riverdale Children's Association
New York City, New York
Counselling children in long term foster care, their parents and foster parents; development and supervision of a group home for adolescents (five years work experience).
Social work supervisor (one year work experience).

The City of Edmonton
Social Services Department
Edmonton, Alberta
Counselling in areas of probation, child protection, family counselling (five months work experience).
Social work supervisor of a children's aid and family counselling unit (one and a half years work experience).
Group and Special Services Supervisor (one year part time work experience).

RELATED WORK EXPERIENCE (CONTINUED)

University of Calgary
School of Social Welfare
Calgary, Alberta

Supervision of four second year M.S.W. students in a field work practicum in Edmonton (for eight months).

Student Counselling Services
University of Alberta
Edmonton, Alberta

Counselling students in relation to career, academic and personal concerns.

Supervision of Educational Psychology Masters and Ph.D. students in a Counselling Psychology program. (Three and a half years as a part time sessional counsellor, four years as a full time counsellor).

TEACHING EXPERIENCE

University of Calgary
School of Social Welfare
Calgary, Alberta

Communication and Social Work Interaction (one term).

University of Alberta
Educational Psychology Department
Edmonton, Alberta

Ed. Psy. 269 (Introduction to Educational Psychology: Maturation and Development). Seminar leader (one term).

Ed. Psy. 271 (Introduction to Educational Psychology: Learning). Seminar leader (one term).

Ed. Psy. 411 (Introduction to Guidance). Team teaching (one term).

University of Alberta
Faculty of Extension

Speaking in Social Groups (one six week and one eight week session).

APPENDIX F

REQUEST FORM FOR DESCRIPTIONS OF ERUPTIVE AND CONGEALING RESPONSE PATTERNS

Keleman talks about two fundamental characteristics of living that he labels self-extending (expansive) and self-collecting (solidifying). A person in the former phase disperses his experience into the world, moves out into the social world. A person in the latter phase gathers his experience to himself, has more contact with himself than the world.

Keleman used the above descriptions in his definitions of two styles of dying--eruptive and congealing. The eruptive style is consistent with the self-extending phase in which the organism explodes, breaking out of its boundaries into the world. Strokes and heart attacks are examples of eruptive dying. The congealing style is associated with the self-collecting phase. It is the opposite of the eruptive. It is self-inhibiting, withdrawing. Such a style of dying is often characterized by a series of illnesses, frequently lengthy.

Will you please write down adjectives or short phrases that you view as descriptive of each style of dying and each style of living (in verbal opposites as if on a semantic differential scale).

Dying Style

Eruptive Congealing

Living Style

Eruptive Congealing

APPENDIX G

THE LIVING-STYLE/DYING-STYLE QUESTIONNAIRE

THE LIVING-STYLE/DYING-STYLE QUESTIONNAIRE

PART A

We would like to know something about your view of yourself. In relation to the experiences that you identified in our discussion (other than those related to terminal illness and/or dying), how would you generally rate your behavior? Please place a circle around the number that you think most accurately describes your behavior.

involved	1..... 2..... 3..... 4..... 5..... 6..... 7.....	detached
angry	1..... 2..... 3..... 4..... 5..... 6..... 7.....	resigned
fearless	1..... 2..... 3..... 4..... 5..... 6..... 7.....	fearful
passive	1..... 2..... 3..... 4..... 5..... 6..... 7.....	active
expressive	1..... 2..... 3..... 4..... 5..... 6..... 7.....	inhibited
rational	1..... 2..... 3..... 4..... 5..... 6..... 7.....	impulsive
withdrawing into self	1..... 2..... 3..... 4..... 5..... 6..... 7.....	moving toward others
dependent	1..... 2..... 3..... 4..... 5..... 6..... 7.....	independent
leader	1..... 2..... 3..... 4..... 5..... 6..... 7.....	follower
introverted	1..... 2..... 3..... 4..... 5..... 6..... 7.....	extroverted
victim	1..... 2..... 3..... 4..... 5..... 6..... 7.....	participant
withdrawn	1..... 2..... 3..... 4..... 5..... 6..... 7.....	volatile
quiet	1..... 2..... 3..... 4..... 5..... 6..... 7.....	verbal
disruptive	1..... 2..... 3..... 4..... 5..... 6..... 7.....	conforming
controlled	1..... 2..... 3..... 4..... 5..... 6..... 7.....	explosive
asocial	1..... 2..... 3..... 4..... 5..... 6..... 7.....	social
easy-going	1..... 2..... 3..... 4..... 5..... 6..... 7.....	frenetic
cautious	1..... 2..... 3..... 4..... 5..... 6..... 7.....	adventurous
radical	1..... 2..... 3..... 4..... 5..... 6..... 7.....	conservative

seeking solution	1..... 2..... 3..... 4..... 5..... 6..... 7.....	seeking relief
public	1..... 2..... 3..... 4..... 5..... 6..... 7.....	private
closed	1..... 2..... 3..... 4..... 5..... 6..... 7.....	open
playing it safe	1..... 2..... 3..... 4..... 5..... 6..... 7.....	taking risks
defensive	1..... 2..... 3..... 4..... 5..... 6..... 7.....	vulnerable
accepting	1..... 2..... 3..... 4..... 5..... 6..... 7.....	rejecting

THE LIVING-STYLE/DYING-STYLE QUESTIONNAIRE

PART B

In relation to the experience of terminal illness and/or dying that you identified in our discussion, how would you generally rate your behavior? Please place a circle around the number that you think most accurately describes your behavior.

involved	1..... 2..... 3..... 4..... 5..... 6..... 7.....	detached
angry	1..... 2..... 3..... 4..... 5..... 6..... 7.....	resigned
fearless	1..... 2..... 3..... 4..... 5..... 6..... 7.....	fearful
passive	1..... 2..... 3..... 4..... 5..... 6..... 7.....	active
expressive	1..... 2..... 3..... 4..... 5..... 6..... 7.....	inhibited
rational	1..... 2..... 3..... 4..... 5..... 6..... 7.....	impulsive
withdrawing into self	1..... 2..... 3..... 4..... 5..... 6..... 7.....	moving toward others
dependent	1..... 2..... 3..... 4..... 5..... 6..... 7.....	independent
leader	1..... 2..... 3..... 4..... 5..... 6..... 7.....	follower
introverted	1..... 2..... 3..... 4..... 5..... 6..... 7.....	extroverted
victim	1..... 2..... 3..... 4..... 5..... 6..... 7.....	participant
withdrawn	1..... 2..... 3..... 4..... 5..... 6..... 7.....	volatile
quiet	1..... 2..... 3..... 4..... 5..... 6..... 7.....	verbal
disruptive	1..... 2..... 3..... 4..... 5..... 6..... 7.....	conforming
controlled	1..... 2..... 3..... 4..... 5..... 6..... 7.....	explosive
asocial	1..... 2..... 3..... 4..... 5..... 6..... 7.....	social
easy-going	1..... 2..... 3..... 4..... 5..... 6..... 7.....	frenetic
cautious	1..... 2..... 3..... 4..... 5..... 6..... 7.....	adventurous
radical	1..... 2..... 3..... 4..... 5..... 6..... 7.....	conservative
seeking solution	1..... 2..... 3..... 4..... 5..... 6..... 7.....	seeking relief

public	1..... 2..... 3..... 4..... 5..... 6..... 7.....	private
closed	1..... 2..... 3..... 4..... 5..... 6..... 7.....	open
playing it safe	1..... 2..... 3..... 4..... 5..... 6..... 7.....	taking risks
defensive	1..... 2..... 3..... 4..... 5..... 6..... 7.....	vulnerable
accepting	1..... 2..... 3..... 4..... 5..... 6..... 7.....	rejecting

APPENDIX H

KEY FOR THE LIVING-STYLE/DYING-STYLE QUESTIONNAIRE

KEY FOR THE LIVING-STYLE/DYING-STYLE QUESTIONNAIRE

*	E	involved	detached	C	**
	E	angry	resigned	C	
	E	fearless	fearful	C	
	C	passive	active	E	
	E	expressive	inhibited	C	
	C	rational	impulsive	E	
	C	withdrawing into self	moving toward others	E	
	C	dependent	independent	E	
	E	leader	follower	E	
	C	introverted	extroverted	E	
	C	victim	participant	E	
	C	withdrawn	volatile	E	
	C	quiet	verbal	E	
	E	disruptive	conforming	C	
	C	controlled	explosive	E	
	C	asocial	social	E	
	C	easy-going	frenetic	E	
	C	cautious	adventurous	E	
	E	radical	conservative	C	
	C	seeking solution	seeking relief	E	
	E	public	private	C	
	C	closed	open	E	

(Cont'd.)

KEY FOR THE LIVING-STYLE/DYING-STYLE QUESTIONNAIRE (Cont'd.)

C playing it safe----------taking risks E

C defensive----------vulnerable E

C accepting----------rejecting E

* E=Eruptive

** C=Congealing